Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Vear Pasquale Paul Pellegrino a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death Plata var les Medica | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | October 5, 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 □ xM 2 □ F New York 117-30-7120 70 1938 Director Usual Residence of Decedent 10c. City, Town or Location with the Maryland 10a. State 10b. County 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Exa⊤incr must be notified at 1 □Yes 2 No Director Maryland Charles Waldorf 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2688 Pinewood Drive 20601 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑4 ves 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married legitino, Pasquale Mi Baltimore, Maryland 21215-0036 1 □Yes 2 No White Specify: þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Congress and Mental Hygiene. Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Scientific Meteorologist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ferdinando Pellegrino Mary Anastasia traumatic ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any Injury or other traigne. Salley Pellegrino/Wife 2688 Pinewood Drive, Waldorf, MD 20601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State May Trinity Memorial Gardens Waldorf, Maryland 4 Denation 5 ☐ Other (Specify) 2009 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 21. Signature of Fu neral Service Licensee Var nouth 30195 Three Notch Rd., Charlotte Hall, MD 20622 MO0817 23a. Part1. Entur the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical onsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine and burial-tran pe exec Box 68760. Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy ģ in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. 1 □Yes 2 □No the 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ð 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate perform Division of Vital 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? examiner? 1 ⊟ Yes 2 🖺 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Anpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28d. Describe how injury occurred After Certification: Hospital or Attending 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie

1010

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL.

Fort Washington Mp

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Khaninoll

32. Registrar's Signature

09-04014 Paul Theron Penrod

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 17502

		- For State	C	ertificate of	Death				Reg. N	lo.		
Physicial edical Examin	1/	I. Decedent's Name (First, Middle,Las Paul Theron Penrod	t)					2. Date of I Month May 20	Da)		. Time of Death 1057 hrs
		a. Facility Name (if not institution, giv St. Mary's Hospital	e street and number)	4	b. City, Tov Leonard		cation of De			4c. County of St. Mary's	6	
Funeral Director			7. Age (In yrs	s. last birthday) 8 Yrs.	If Under Months	1 Year Days	If Under 24	dia.		1941	Coun	olace (State or Foreign try) yland
AD 21215-0036 2 should be filed within 72 hours after death with it and Mental Hygiene. 27 is marked other than "natural", or items 23, marice event, the Medical Examiner must be no	To Be Completed by Funeral Director	Jsual Residence of Decedent 10a. State Maryland St.Ma 10e. Street and Number 25160 Pinto Drive 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify of Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last Theron Luther Penrod 19a. Informant's Name/Relationship (Judy Diane Penrod / 20a. Method of Disposition 1 Burial 2 Cremation 3	12. Was Decedent Ever in Armed Forces? 1	19b Mailing 25160	s Decedent es, specify Yes 2 2 t's Usual Ocost of worki f Petty g Address Pinto I sition (Nameher place)	206: t of Hispac Cuban, No ccupationing life. D (Street a Drive e of cemes	inic Origin? Mexican, Pue specify: In (Give kind IO NOT use icer I.Mother's No G and Number Holly etery, M		neva Number 2063	White, Specify: bb. Kind of Bus U.S. Meden Surname) Butler r, City or Town	America etc. White siness/incomess/inc	ze dustry Zip Code)
Baltimore, he saltimore, he saltimore, he saltimore of Healt and begardment of Healt in injury or other trau		Donation 5 Other Specify Signature of Funeral Service Lice 23a. Part I. Enter the disease, or comfailure. List only one cause on elimmediate Cause (Final disease or condition resulting in death)	See Jardine Dications that caused the de	ath. Do not enter t	Name and A Matting P.O. Bo	Address of 1919	of Facility Gardine O Leon	r Funera ardtown, ac or respirato	1 Hom MD 2	ne, P.A.		Approximate interval Between Onset and Death
execut an and al - tra	Medical Examiner	Sequentially list conditions, if any, leading to immediate course. Error Lindentying Course (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence) Due to (or as a consequence) AMENDED									
P.O. Box 68 es that the death certifigned by the attending or detached for use as	ysician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow Part II. Other significant conditions Chronic Obstructive Pull	contributing to death but n	of death 2 Fe		cause gi	Ectopic pr	. 23e. 1 24a.	Yes Was an autopsy perform	2 No 3	Prob Were autorior to codeath?	ay Year the cause of death? ably 4 Unknown topsy findings available ompletion of cause of s 2 No
- i ^ a	To Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 ✓ Accident Investiga	28a. Date of Injury FOUND: POUND:	ER/Outpatien 28b. Time of FOUND: 1010 hrs	nt 3 D	OA C	Mh an a	lursing Home 28d. Des Subjec	cribe ho	esidence 6 [w injury occur use fire		:
Division To the Hospital or Attendin within 24 hours after death To the Funeral Director: ^	al Certification:	3 Suicide 6 Could no determin 4 Homicide 29a. Certifier 1 Certifying Physics	t be 28e. Place of Injury - ed (Specify) Single f	Family Home	urred at the	time, da	te and place	or To 25160 P	own, Sta into Dri e cause	ite) ive, Hollywoo (s) and manne	od, MD eras state	ral Route Number, City
To the Hos within 24 h To the Fur completely	Medical	29b. Signature and title of certifier	er:On the basis of examinati and manner stated.	on and/or investiga	ation, in my	opinion,	death occu	red at the time	, date ar	nd place, and	due to th	e cause(s) nth, Day,Year)
		30. Name and address of person who Patricia Aronica-Pollak M	ID. Assistant Medic	cal Examiner	111 Pe	enn Str	eet, Balt	more, MD	21201			
St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature		P						

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 14 2009 10:35 PM F. May Barbara Parsels /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico Salisbury Wicomico Nursing Home If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗓 F 9-8-1915 93 New Jersey Director 148-22-0325 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ms 23a or 28a-f show must be notified at 1 ☐ Yes 2X No **Funeral Director** Sharptown Wicomico 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 404 Joe Morgan Road 21861 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items any Injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. Specify: White þ 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Wa 11 Mingle 2 William 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter J. Parsels, Jr. - Son P.O. Box 95, Sharptown Rd., Sharptown, MD 21861 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🛛 Removal from State 4 Donation 5 Dother (Specify) 5-26-2009 Clarksboro, New Jersey Eglington Cemetery 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service Licensee 705 E. Main Street, Salisbury, Maryland 21804 23a. Paper. Enter the disease, or complice shock, or heart failure. List only go stions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Dav 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 1 Yes 2 No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ №6 24a. Was an s certificate has b lirector, page 2 sl autopsy performe 2 10 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation ✓ Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Pate signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) Mahesha Thimmarayappa M.D.

31. Date filed (Month, Day, Year) | 32. Registrar's Signa 614 Easternshore Dr Salisbury MD 21804 31. Date filed (Month, Day, Year) State MAY 18

Registrar

Mire Portee

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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1 ,	4a. Facility Name (if not instituti		ber)		vn, or Location of	of Death		4c. County of Dea	
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Funeral	5. Social Security Number		. Age (In yrs. last birthda	Months	1 Year If Under Days Hours		3. Date of Birth (irthplace (State or Foreign ountry) GA
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tien 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	21. Signature of Funeral Service		01085	ZZ. Name and A	odress of Facilit	Pope	Funeral	Homes, H	'.A.
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ox 6 Ith cer	past 12 months?	nlanaum I	nt at time of death 5	Other (Speci	fy)				Ш
). Box 6876 the death certificate the death certificate by the attending physched for use as the Physician/M	Part II Other significant cond	9 Unknow		n the underlying	auco airen in P	Part I	23e Did tob	acco use contribute	to the cause of death?
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	/1/11	1 - (41		O.C.M.E.			May 9, 2009	
	30-Name and address of person	on who completed cause	e of death (Item 23a)	_					
	Zabiullah Ali, M.D.	Assistant Medica	/	l Penn Street	, Baltimore,	MD 2120	01		
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215 be file ntal H rked o	Be (J	OAO de	DEUS ME	SQUITA	40h Mailing	Adress (Stre	et and Nur	SOLE	TNA Iral Route Nu	ımber, City or	Town, St	ate, Zip Code)
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	iner		o immediate Inderlying Cause										
	Examine	(Disease or inju	ury that initiated in death) Last	Due to (or as a con	sequence of):								
cuted				d23	la.27.p	erME,	g892 6,	/19/09	9 TT				
30, te be execut ysician and	ched for use as the burial - us	XUNPEND	DED								23d. D	ate of de	
ords, P.O. Box 68760, aw requires that the death certificate be example to the strending physician ras been signed by the attending physician	the bu	IF FEMALE:	ient pregnant in the	23c. If yes, outc			tal death	3 Ecto	pic pregna	ancy	Mo	onth	Day Year
certif	use as	past 12 mo	onths?		at time of dea		her (Specify)						
Box death he atte	d for	1 Yes 2	✓ No 9 Unkno			eulting in the	inderlying call	se given in	Part I.				ute to the cause of death?
O. I at the	etache		significant condition	s contributing to de	ath but not re	sulfing in the	Jilderlying ode.	9		1	Yes 2	10 3	Probably 4 V Unknow
b, P.O. irres that the signed by	d be d										Vas an	24b W	ere autopsy findings availa or to completion of cause o
ords v requ	shoul	Completed								F	erformed?	de	eath? ✓ Yes 2 No
ecol he law ate has		E					- 00 F	lace of De	oth (Check		es 2 No		
tal Rec cian: The certificate		25. Was case examiner?	referred to medical	Hospital:		ED/Outsetier		Other;		ing Home	Residence	ce 6 🗸	Other: Scene
Vita hysici this o	·==	O 1 Yes	2 No	ı l	atient 2	ER/Outpatier 28b. Time of		Injury at W		-	ribe how injury	y occurre	ed
Of ing PI	iner			28a. Date of (Month, D	ay,Year)	2001		Yes 2		ì			
ion ttendi death	y the f	2 Accid	laura eti		of Injury - At h	ome, farm, str	eet, factory, off	ice building	g, etc.	28f. Loca	ion (Street an	d Numbe	er or Rural Route Number,
Division of Vital Records, tal or Attending Physician: The law requirm and affected the angle of the physician and the specificate has been significate that been significant that the specificate has been significant that the specificant has been significant that the specificant tha	d in b	1 X Nature 2 Accide 3 Suicide 4 Homi	determ	not be (Specify)							wn, State)		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 brours after death. To the Femeral Director: After this certificate has been signed by the attending physician and			cide		of my knowled	ige, death occ	urred at the tim	ne, date an	d place, a	nd due to the	cause(s) and	manner	as stated.
he Ho in 24 he Fu	pletel	(Check only one) 29b. Signatur	2 Medical Exam	vsician: To the best of niner:On the basis of and manner sta	examination a	and/or investig	ation, in my op	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		at the time,			ed (Month, Day, Year)
Tot	com	29b. Signatur	e and title of certifier	and manner sta			29c. L	icense nun	nber		290. L	ALE SIGIN	sa (Month, Bay)
			Just 60	Their MAN				D.C.M.E.			May	16, 20	
	- 1	30 Name an	d address of person	who completed cause	of death (Iter	m 23a)			-14	MD 040	n1		
	Ì		a E. Southall, M	D Assistant N	fedical Exa	aminer	111 Penn S	treet, Ba	aitimore	, IVIU Z IZ			
	St	ate 31. Date filed	(Month, Day, Year)	40	ustrar's Sigr	ture pay	las						
Re	eaist		IIIN 0 1 20	09 Seven	~ ~.	17							

DHMH 17 Rev 1/2001

09-03426 Ralph Raley Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 17507

		I- For State Registrar			Ce	ertificate	of Dea	atn									
Physicia	an/	 Decedent's Name (First 		t)						-	1	Month	Day	Year			
dical Exami		Ralph J. Ral	<u> </u>								_	April 28,	2009			1951 1118	·
		4a. Facility Name (if not in		e street and no	umber)			y, Town, o		on of D	April 28, 2009 If Death Allegany If 24Hrs. In 24Hrs. In 24Hrs. In 25 Eptember 30, 1922 In 24Hrs. In 3. Date of Birth(MM/DD/YYYY) September 30, 1922 In 3. Date of Birth(MM/DD/YYYY) September 30, 1922 In 3. Date of What Country? U.S.A. In 3. Citizen of What Country? U.S.A. In 3. Citizen of What Country? U.S.A. In 4. Race - American Indian, Black, White, etc. Specify: White In 3. White In 4. Race - American Indian, Black, White, etc. Specify: White In 4. Race - American Indian, Black, White, etc. Specify: White In 4. Race - American Indian, Black, White, etc. Specify: White In 4. Race - American Indian, Black, White, etc. Specify: White In 4. Race - American Indian, Black, White, etc. Specify: White In 4. Race - American Indian, Black, White, etc. Specify: White In 4. Race - American Indian, Black, White, etc. Specify: White In 4. Race - American Indian, Black, White, etc. Specify: White In 4. Race - American Indian, Black, White, etc. Specify: White In 4. Race - American Indian, Black, White, etc. Specify: White In 4. Race - American Indian, Black, White, etc. Specify: White In 4. Race - American Indian, Black, White, etc. Specify: White In 4. Race - American Indian, Black, White, etc. Specify: White In 4. Race - American Indian, Black, White, etc. Specify: White In 4. Race - American Indian, Black, White, etc. Specify: White In 4. Race - American Indian, Black, White, etc. Specify: White In 4. Race - American Indian, Black, White, etc. Specify: White In 4. Race - American Indian, Black, White, etc. Specify: White In 4. Race - American Indian, Black, White, etc. Specify: White In 4. Race - American Indian, Black, White, etc. Specify: White In 4. Race - American Indian, Black, White, etc. Specify: White In 4. Race - American Indian, Black, White, etc. Specify: White In 4. Race - American Indian, Black, White In 4. Race -						
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Funeral		5. Social Security Number		ex		. last birthday)	_	nder 1 Ye		ours		8. Date of I	Birth(MM/E		oreign		
Director		217-18-440	15	M 2 F		86	rs.	TILLIS DA	iys Ho	Jul 5		Septer	mber 30), 1922	Coun	ennsyl	/ania
		Usual Residence of Dece													- 1		
any		10a. State 10b. 0			10c. Ci	ty, Town or Lo											
nd Show	<u>_</u>	PA	Son	nerset		Meyers	date								1	Yes	2 X No
aryla 8a-f	동	10e. Street and Number					10f.	Zip Code					_		Country	?	
eath with the Maryland items 23a or 28a-f show ust be notified at one.	Director		3956	Greenvill	le Road			1553	52-					U.S.A.			
vith t s 238 e not		11. Marital Status		12. Was De	cedent Ever in								No-			Indian, Bl	ack,
item item	Funeral	1 Never Married 2	Married	1 X Yes	Forces?		If Yes, sp	ecify Cub	an, Mexic	can, P	uerto R	ican, etc.)		wnite, e			
her d		3 Widowed 4	Divorced	If Yes, Give Ye	ar WW I		Yes	2 X N	No spec	cify:				Specify:	V	/hite	
hours at 'natural Examin	d by	15. Decedent's Education		or Dates:		16a. Dece	dent's Usi	ual Occup	ation (G	ive kin	d of wo	rk done	16b. K	and of Busin	ness/Indu	ustry	
72 ho	Completed	Elementary/Secondary	(0-12)	College ((1-4 or 5+)		ectricia		te. DO N	OT us	e retire	a)		glass m	าลทบริ	cturer	
215-0036 be filed within 72 ntal Hygiene. rked other than ent, the Medical	du	12		Ū		,								8			
5-0 ed wi lygie other	ပ္ပ	17. Father's Name (First,	Middle, Last)					18.Mo		,		e, Maiden	glass manufacturer laiden Surname) ber, City or Town, State, Zip Code) d Maryland 21532- 20c. Location - City or Town, State Pocahontas Pennsylvania ve., Frostburg, MD 21532 est, shock, or heart Approximate Interval Between Onset and			
121(ld be fill fental F	Be	Charles T.	Kaley										//				
21 ould d Mer s man	2	19a. Informant's Name/R				19b. Ma	iling Addr	ess (Str	reet and	Numbe	er or Ru	ral Route N	iumber, Ci			ip Code)	1522
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Ileath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	1	Richard E.	Raiey	80													
Te, and I lead I		20a. Method of Disposition 1 Burial 2 Cr		V Pamayal		 b. Place of Dis crematory o 	r other pla	ace)		/·				Location - C	ity or 10		
Pages 1 nent of 11 ant: If i		4 Donation 5 C		/	IIOIII State	Gree	nville (Cemete	гу		M	lay 02, 20	09]	Pocahon	tas	Pennsy	/lvania
.= 2 5 0	3	21. Signature of Funeral	Service Lice	1 30 0	1	2	2. Name										_
Balt permit. Departi Importinjury		John.	R	Duri	1								-		4	D 2153	2
Physician		23a Part I. Enter the dise failure. List only on	ase, or com	plications that	caused the dea	ath. Do not ent	er the mo	de of dyir	ng, such	as car	diac or	respiratory	arrest, she	ock, or hear	t		
'Medical	1	Immediate Cause (Final			erotic Cardi	ovascular i	Disease	9								De	ath
taminer		or condition resulting in			a consequenc												
		Sequentially list condition	ns, b	·											-		
	iner	if any, leading to immedi-		Due to (or as	a consequenc	e of):											
	Examiner	(Disease or injury that in events resulting in death	tiated C	Due to (or as	a consequenc	e of):											
uted nd ransit			, c	l	_												
3760, finate be executed g physician and s the burial - transit	n/Medical	UNPENDED		AMENDED)												
ອ ≑ ອ	Me	IF FEMALE:		23c. If yes	s, outcome of p	regnancy							23	d. Date of d	elivery		
587 ertific	au/	23b. Was decedent pregr past 12 months?	ant in the		birth	2	Fetal de	eath	3 E	ctopic _I	regnar	псу		Month	Da	У	Year
Box 61 e death cert the attendir	Sici	1 Yes 2 No 9	Unknow		gnant at time o	r death 5	Other ((Specify)									
P.O. Box 687, s that the death certifica gned by the attending p e detached for use as th	Physicial			90118	to death but n	ot reculting in	the under	lvina caus	se given	in Par		23e. D	id tobacco	use contrib	oute to th	e cause of	death?
P.O. s that the gned by e detacl	by F	Part II. Other significan	Conditions	Contributing	(to death but in	ot resulting in	ile dildei	iying odd.	oc givon			1					
ords, P.O. I v requires that the sbeen signed by t	Pa											24a W	/as an	24b. W	ere auto	psy finding	s available
ords, w requir us been s should	bet											а	utopsy	pr	rior to cor		
ecc he lav ate ha	Completed															2	No
tal Rec cian: The l certificate l		25. Was case referred to	medical	est to be a				26.PI			Check o	only one)					
Vita ysicis his ce direc	o Be	examiner?	No	Hospital: 1	Inpatient 2	ER/Outpa	tient 3	DOA	Othe	4	Nursin	g Home 5	Resid	ence 6 🗸	Other:	Scene	
Division of Vital Records, la or Attending Physician: The law requiring and again and a start death. In Director: After this certificate has been sized in by the fineral director, page 2 should the control of the co	=	27. Manner of Death		28a. Da	ite of Injury nth, Day, Year)	28b. Time	of Injury	28c.	Injury at	Work?		28d. Descr	ibe how in	jury occurre	d		
On endir ath or: ^	₽	1 V Natural 5	Pending		,,			1	Yes	2	No						
risi r Attr er de irecte	<u>밀</u>	2 Accident 3 Suicide 6	Investigation	28e PI	ace of Injury - A	At home, farm,	street, fa	ctory, offic	ce buildir	ng, etc				and Numbe	r or Rura	Route Nu	ımber, City
Division spital or Attendours after death neral Director: filled in by the	Certification:	3 Suicide 6 4 Homicide	determin		fy)							or lov	ni, state)				
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certivation 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a		29a. Certifier 1 Cert	fying Physi	cian: To the b	est of my knov	vledge, death	occurred a	at the time	e, date ar	nd plac	ce, and	due to the	cause(s) a	nd manner	as stated	d.	
To the Hos within 24 h To the Fur	Medical	one) 2 • Med	cal Examin	er:On the bas	is of examination	on and/or inve	stigation,	in my opi	nion, dea	ath occ	urred a	t the time, o	date and p	lace, and di	ue to the	cause(s)	
- LINE 2 3	₩ W	29b. Signature and title	of certifier	and manne	a Stateu.		-	29c. Lic	ense nur	mber			29d	. Date signe	d (Mont	h, Day.Yea	ar)
	ĺ	100	411	. 11 -1	λ			0.	.C.M.E				Ap	ril 29, 20	09		
5+		30. Name and address of	MITALL TO WA	o completed of	ause of death (Item 23a)		L.,									
1000		Pamela E. Sou			nt Medical E		111 P	enn Str	eet, B	altim	ore, N	/ID 2120	1				
MRS	12.17				Registrar's Sig												
Regi	itate stra:	N 1 11 1 '4	U 2009	ans	un B	. Jan	May 1										

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Marie T. Robustelli May 11:45P^M 2009 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Berlin Nursing Home Berlin Worcester 8. Date of Birth (Month Day Year) 7/30/1920 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 88 NY **Director** 068-05-9555 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9715 Healthway Dr. 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No þ Specify. Specify: white 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Checker Food 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Andrew Scimeca Angelina Spano ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela Calabro / daughter 3 Dog Leg Court, Ocean Pines, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 5/18/2009 | Mayrest Cemetery 4 □ Donation 5 □ Other (Specify) Mahwah, NJ 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 Part . Interity disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shool or most failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediav Cause (Final disease r condition resulting in death) Physician ASCUO /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury Examiner Due to (or as a consequence of): as the burial-tran resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes V 🗹 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Melletins Diosete 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 □ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes Z ☐ No Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To nours after death.

neral Director: After this
y filled in by the funeral di 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 03/13/09 1) 63194 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAL YOGESH VOHRA 614 EASTERN SHORE DR SALISBURY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 15 2009 Registrar

DHMH 17 Rev 1/2001

Maryland 21215-0036

bustelli

Baltimore,

or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death Year May 11. 2009 Physician Lillian B. Reamy 16:15P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** 1 M 2 A 91 Virginia Director Aug 3. 577 12 9937 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Charles Waldorf 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with 2744 Moran Drive 20604 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 □ No Baltimore, Maryland 21215-0036 Specify: Specify ò White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade com (Give kind of work done during most of working life. DO NOT use retired) grade completed, and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Vice President of Aig INS. Insurance Underwriter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be in nent of Health and Mental Robert Hynson Ida Bewen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health at Important: If item 27 is any Injury or other trau once. Dennis Reamy (SON) 7406 Tildem St. Hyattsville, MD 20784 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Christ Church Cemetery May 20,2009 Clinton, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature eeral Service Licensee 20735 Alexandria Ferry Road, Clinton, MD Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Partit Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) **Physician** NEUMONIF /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Date to for as a consequence of attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Tectopic pregnancy Month in the past 12 months? Day 5 ☐ Other (specify) signed by the a 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed After this certificate has been s funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 🗷 No 1 □Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred (Month, Day, Year) Injury 5 ☐ Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director; A: completely filled in by the fu 1 ∏Yes 2 ∏No death. 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar 31. Date filed (Month, Day, Year) MAY 152009

30. Name and address of person who com

29b. Signature and title of certified

ed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

			For State Registrar	State o	f Marylan	•	artment r <i>tificate</i>			d Me	ental F	lygien Reg. N	_ Z U	09	17	510
	Physicia		1. Decedent's Name (First, Middle John Wes1		Sr.					N N	2. Date of Month May 1	Death 0,20	09	Year	3. Time of 10:34	
	/Medic Examin		4a. Facility Name (If not institution 9602 Jul	, give street and nur			4b. City, To		nton				c. County		eorge'	s
H	Funeral Director		5. Social Security Number 577 52 8826	6. Sex 1 □ XM 2 □ F	7. Age (In yrs. i	ast birthday) Yrs.	If Under 1 Months	Year Days	f Under 24 H Hours M	in.	3. Date of (Month, May	Birth Day Yea 27,	1938	9. Birthp Coun Wash	lace (State of try) ningto	or Foreign n, DC
	show	ī	Usual Residence of Decedent 10a. State 10b. County MD P.	G.		y, Town or Lo		<u> </u>						1	0d. Inside Ci	
	th the Ma or 28a-f s e notified	Directo	10e. Street and Number				10f, Zip (10g. (Citizen of W		try?	A.N.
0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: I flem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I've Medical Examiner must be notified at once.	Funeral Director	9602 Julie 11. Marital Status 1 □ Never Married **XMarr	12. Was Dece Armed Fo	edent Ever in U. rces? 2 No		Was Decede If Yes, specif		anic Origin? Mexican, Pu	(Spec erto Ri	cify Yes or ican, etc.)	No-	Black	e - Americ k, White, e	an Indian, etc.	
0500-61	n 72 hours a " natural", c edical Evan	Completed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent (Specify only highes	If Yes, Given Year or D 's Education 's Education 's grade completed)	ve ates:	16a. Dece	1 □ Yes 2 dent's Usual kind of work DO NOT use	Occupati done dui	Specify: on ring most of v	working	3	16b.	Specify. Kind of Bu	44117		
717	fled withir Hygiene. Ither than nt, he m		Elementary/Secondary (0-12) 8 th 17. Father's Name (First, Middle,	College (1	-4or 5+)		umber		8. Mother's N	Name ((First. Mid	dle. Maide	Plum en Surnam	_		
yland	should be that and Mental I amarked of umarked of umatic eve	To Be	Rodney		Rice	1 401 14 11			Ar	na	A. L	enz			Cadal	
	and 2 sh lealth and m 27 Is n her traun		19a. Informant's Name/Relations Patricia Rice	nip (Type. Print) (Wife		96	02 Ju1	.iett	d Number or e Driv	re,	C1in	ton,	MD	2073	35	
altimore	Pages 1 ment of H ant; If ite ury or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		State	lace of Dispo emetery, crer Lee Cr	emator	у	May 1		2009	C	Location -	n, MI)	
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a. F	hysician		23a. Part1. Enter the disease, or shock, or heart fourte. List Immediate Cause (Fin disease or condition	complications that conly one cause on e	aused the death each line.	h. Do not en	ter the mode	of dying,	such as care	diac or	respirato	ry arrest,			Approximat Interval Bet Onset and	te tween Death
4	/Medical Examiner	Į,	resulting in death)	Due to	(or as a consequ	uence of):									5/10/09	9 MM
,	cate be executed onlysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	C	(or as a consequence of a											
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.O. Box	law requires that the death certific as been signed by the attending p 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	tcome of pregna birth 2 Peta nant at time of c nown	Ideath 3	☐ Ectopic pre☐ Other (spe							e of deliventh	•	Year
ras, r	quires that an signed b uld be deta	þ	Part II. Other significant condition	ns contributing to d	eath but not res	ulting in the u	inderlying ca	use given	in Part I.			id tobaco	2 No		he cause of o	
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or vital	Attending Physician: r death. ector: After this certifics by the funeral director, p	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 28a. Date		ER/Outpatie		A Other	4 LI Nursi	ng Hom	ne 5 T	Residence	6 ☐Oth		fy)	
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2	ortal or Al urs after or ral Direc		4 ☐ Homicide determ	ined 28e. Place build	of Injury - At he ing, etc. (Special	'y) 					City or	Town, St	tate)		al Route Nur	nber,
	To the Hospital or within 24 hours afte To the Funeral Director Completely filled in I	Medical	(Check only 2 Medical one)		pasis of examination of the state of the sta	ation and/or in	nvestigation,	in my opi	nion, death o	occurre	ed at the ti	me, date	and place,	and due t	o the cause((s)
N	o w _{iti} o	2	29b. Signature and title of certifie	Do			296.	H 60	067.5	60		290.	5	40	Day, Year)	
4	Basil		30. Name and address of person	who completed cause	se of death (Iter	n 23a) (Type,	Print)	, Te.	ple 6	hee	, 17	D		, ,		
	Sta Registr		31. Date filed (Month, Day, Year)	5 2009 32. F	Registrar's Signa	ature 1. 4	back	1	U		•					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🥎 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 7:10 MM 2009 J. 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) WASHINGTON HAGERSTOWN, MD JULIA MANOR If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Year Days 1 □ M 2 🛱 F 73 March 15 1936 Pennsylvania 217<u>-32-7085</u> Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ∐ Yes 2√∑ No Maryland | Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21740 15917 Rhododendron Drive Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 📉 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dry Cleaners 6 0 Presser 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lawson Keller Isabel Kneisley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 15917 Rhododendron Dr. Hagerstown, MD. 21740 Sheri L. Shatzer-Daughter-in-law 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park | 5/16/09 Hagerstown, Maryland 22. Name and Address of Facility Minnich Funeral Home 4415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final arge cell lymphomo disease or condition resulting in death) Due for as a consequence of): tive pulmonary disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ingestive hear Due to (or as a consequence of): INSUFFICI 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 🗆 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 X No 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural

Physician /Medical **Examiner** law requires that the death certificate be executed

Physician

/Medical

Examiner

Directo

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Completed

Be ပ

Funeral

Director

filed within 72 hours after death with the Maryland

Pages 1 and 2 should

t of Health a

item 27

Department of Important: If it any Injury or o once.

Maryland 21215-0036

Baltimore,

Box 68760.

P.0.

Records,

Division of Vital

d 2 should be filed within 72 hours after death with the Marylan thit and Mental Hyglene. It han death at the same 23a or 28a-f show that marked other than "natural", or items 23a or 28a-f show traumatic event, It we died it zeningen mast be notified at

burial-trar physician a attending p for use as t the þ s been signed b icate has t page 2 si certificate To the Hospital or Attending Physician: director, this tin 24 hours after ueau...

the Funeral Director: After this

Physician/Medical Completed Be မ Certification:

Medical

Examiner

IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

27. Manner of leath

29a. Certifier

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Hagerstown, MD 21740

(Check only one) and manner stated. 29b. Signature and title of certifier

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

ed cause of death (Item 23a) (Type, Print)

State Registrar

completely

within To the

31. Date filed (Month,

			Amended 10g. Please Type or Print in E	Black Inc	delible lnk.	Ensure A	I Copies A	re Legibl	e.
			FH _{For} 5/15/09 State of Marylan	d / Depa	artment of H	lealth and N	1ental Hygi	ene 2 n	10 17512
		-	State Registrar	Cer	rtificate of L	Death	Re	g. No.	17016
			1. Decedent's Name (First, Middle, Last)				Date of Death Month		3. Time of Death
	Physicia /Medic		Robert Wayne Shetron				Man	14 200	25
Mary Control	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of	Death
			Washington County Hospital		Hagersto	WN If Under 24 Hrs.	C. Date of Birth	Washin	gton Birthplace (State or Foreign
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,		Country)
١.	Director	-	219-34-7300 71 Usual Residence of Decedent				Nov. 17,	193/	Maryland
	land	1		ty, Town or Lo	ocation				10d. Inside City Limits
	Mary -f sh ied a	호	Maryland Washington Hag	gerstow	m				1 □Yes 2 No
	r 28a	Director	10e. Street and Number	<u>CEDCON</u>	10f. Zip Code		10	g. Citizen of Wha	
	h with		15631 Deer Lodge Circle		21740			ashingto	U.S.A.
	deat	Funeral	11. Marital Status 12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- Rican, etc.)		American Indian, White, etc.
9	after or its	F	1 ☐ Never Married 2 Married 1 ☐ Yes 2 No		1 □Yes 2 No	Specify:		Specify:	
5-0036	within 72 hours after death with the Maryland jeen than "natural", or items 23a or 28a-f show trans "natural", or items 24 be notified at the Maryland Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	16a Doce	dent's Usual Occup	ation		16b. Kind of Busi	White ness/Industry
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d 2	e filed v al Hygie other I vent, II	Be C	17. Father's Name (First, Middle, Last)	HOLLO	-	18. Mother's Nam	ne (First, Middle, N		
an	ld be lental ked (ic ev	To B	Leonard Taylor Shetron Sr.			Alta Mae	Ridenou	r	
Maryland	s should be filed and Mental Hygi is marked other aumatic event, II		19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ng Address (Street	and Number or Ru	ral Route Number	; City or Town, St	tate, Zip Code)
Σ	alth a		Dorothy J. Shetron / wife						yland 21740
altimore,	of He of Heritan		20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State	Place of Dispo cemetery, crea	osition (Name of matory or other plac	ce)	Date	20c. Location - C	ity or Town, State
Ĕ	Page ment ant: If ury o			thsbur	g Cremato				g, Maryland
alt	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item Z7 is marked any injury or other traumatic et <u>once.</u>		21. Signature of Funeral Service Linensee		2. Name and Addre				
8	89 = 89		in his						Maryland 21742
			23a. Part 1. Enter the disease, or complications that caused the dear shock, or heart failure. List only one cause on each line.	th. Do not en	ter the mode of dyir	ng, such as cardiad	or respiratory arre	est,	Approximate Interval Between Onset and Death
The same	Physician		Immediate Cause (Final disease or condition	ng (Concer				9 month
-	/Medical Examiner		resulting in death) Due to (or as a consect	quence of):					
	Lxummon	7	Sequentially list conditions, if any leading to immediate b. Due to (or as a consec	quence of).					
	ted nsit	Examine	cause. Enter Underlying	4401100 017.					
	executed an and rial-transit	xar	Cause (Disease or injury that initiated events c	quence of):					
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68760	tificat ng phy as the	Physician/Medical	4.1-2						
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	death	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Other (specify)			Mon	th Day Year
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	Physician: The law requires that the death certificate be this certificate has been signed by the attending physicia al director, page 2 should be detached for use as the burns of the contract of the contra	by F	Part II. Other significant conditions contributing to death but not re-	sulting in the u	underlying cause giv	ven in Part I.	23e. Did to		3 Probably 4 ☐ Unknown
Records,	v require been si should t	ted					(1)		
ec	has b	Completed					24a. Was a autops perfor	nd vs	/ere autopsy findings available rior to completion of cause of eath?
Ξ.	: The law cate has page 2 s	녕					1 ☐ Yes	2. No 1	□Yes 2□No
Vital	siclan: The certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital:		Ott	hor:	ath (Check only or		
of	Phys this al dir	은	1 ☐ Yes 2 ☐ No Prospital: 1 ☐ Inpatient 2 ☐ 27. Manner of Death 28a. Date of Injury	28b. Time	EUL SEL DON	4 L. Nursing r	lome 5 ☐ Resid	ow injury occurre	
	ding Phys h. After this funeral dir	Ö	1 Natural 5 Pending (Month, Day, Year)	Injury	Wo	rk?]Yes 2∐No			
18.	Vittend death ctor: y the	ficat	3 Suicide 6 Could not be 28e. Place of Injury - At I	l home, farm, st			28f. Location (S	Street and Numbe	er or Rural Route Number,
Division	after Direction	Certification:	4 Homicide determined building, etc. (Spec	cify)			City or Tow	m, State)	
	spita nours neral y fille		29a. Certifier 1 Certifying Physician: To the best of my kr (Check only 2 Medical Examiner: On the basis of examiner)	nowledge, dea	ath occurred at the t	time, date and place	e, and due to the	cause(s) and ma	nner as stated.
	n 24 I	Medical	one) and manner stated.						
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	ž	29b. Signature and title of certifier		29c. Licen	se number		29d. Date signed	(Month, Day, Year)
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	The		29b. Signature and title of certifier Michael Melonack (Ille 30. Name and address of person who completed cause of death (Ite Michael Melonack (Ille 31. Date filed (Month, Day, Year) 32 Registrar's Sign	em 23a) (Type	e, Print)		11	2.	1110
	15		Michael Melormack Illia	nature M	edicul	(mo	102	cru/oun	n prip
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Sign	A be	alal				
	riogist		Common of	1200					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** $A^{\,\mathsf{M}}$ 2009 Miriam 1:00 Straley May Camilla /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Somerford Assisted Living Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F Months Days Hours Min. Director 219-20-3500 Dec. 7, 1921 Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Maddal Examination at the notified at 1 □Yes 2 No Director Maryland Washington Hagerstown 10a, Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 10114 Sharpsburg Pike 21740 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Maryland 21215-0036 Specify: 2 Specify: 3 Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene Important: If Item 27 Is marked other than any Injury or other traumatic event, In. M. once. Elementary/Secondary (0-12) College (1-4or 5+) 12 Textile Manufacturing Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 William H. Springer Bessie Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17225 19a. Informant's Name/Relationship (Type. Print) H. Duane Kinzer / nephew 27 East Baltimore Street Greencastle Pennsylvania altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 Other (Specify) Rest Haven Cemetery 5/16/2009 Hagerstown, Maryland re of Funeral Service Le 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown Maryland 21742 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician OMIC disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** ougrestin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.
To the Fuheral Director: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burlar-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 D Ectonic pregnancy in the past 12 months? Month Day Ye ar 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 No 3 ☑ Probably 4 ☐ Unknown 1 ☐ Yes certificate has been s irector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy 1 🗆 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \timesOther (Specify) Hospital: 1 Yes 21 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manger of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 🗹 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier TS-certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) To the within 2 To the 1 and manner stated.

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Muhammad Waseem MD 1126 Opal Ct. Hagerstown 21740 Maryland

31. Date filed (Month, Day, Year)

MAY 15 2009

29b. Signature and title of certifier

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

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		For State egistrar				Certif	icale of	Death			2.	Date of De				3. Time of I	Death
Physiciar	••	Decedent's Name			-						N	Month May 14,	Day 2009	Ye	ar	1657 h	irs
Mer' ⊃l Examin	er	Harold	Loyd S	eymore	, Jr.		— Т	4b. City, To	wn, or Lo	ocation of			40	. County	of Death		
	4	a. Facility Name (i	f not institution, g ston Creek R		Humber)		1	Californ						St. Mar	-		
				Sex	7 Age (1	n vrs. last	birthday)	If Under	1 Year	If Under	24Hrs. 8	3. Date of	Birth(M M	/DD/YYY	Y) g. Bir Foreig	thplace (Sta	te or
Funeral	- 1	. Social Security N			1			Months	Days	Hours	Min.	03/1	7/19	60		untry) M	
Director		219-92-29		X M 2	F		19 Yrs	·			1						
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213 ould b	P	19a. Informant's N	Name/Relationsh	p (Type, Print)		19b. Mails	ng Address	(Stree	t and Num	nberorRu -∦-12 T	rai Route	at on	Par	k. M	te, Zip Code D 206.	53
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Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	[] C	20a Certifier						occurred at	the time,	date and	place, an	id due to th	ne cause	(s) and n	nanner as	stated.	4-1
To the Hos within 24 h	12	(Check only one)	Certifying F✓ Medical Ex	miner: On the	e basis of ex	amination	and/or inve	stigation, in	my opini	ion, death	occurred	at the time	e, date a	io piese			e(S)
To t With To th	Medical	29b. Signature	and title of certif	anun	anner stated	l				ense numb				29d. Da	te signea	(Month, Da	y, Year)
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12	-	30. Name and		ant Medica	al Examin	er 11	11 Penn S	Street, Ba	altimor	e, MD 2	21201						
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Reg	Stat istra	īr	Month Day e	O SAME	Liter	CARSON CO.	D.	A COLOR									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 11:20A Robert Montgomery Sprowls May 3, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 7, Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Days Hours 1⊠M 2□F 215-32-5180 74 1935 Maryland **Director** Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County ms 23a or 28a-f shorn registed at 1 ☑Yes 2 ☐ No Director D.C. None Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20016 4304 River Road, N.W. USA Funeral 1 and 2 should be filed within 72 hours after deat Health and Mental Hygene. em 27 is marked other than "natural", or items: wither traumatic event, It ... Medical Examiner ma Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No Specify. 1960 Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Design Spectrum College (1-4or 5+) Elementary/Secondary (0-12) Architects Architect 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Montgomery Sprowls Naser ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4304 River Rd., N.W. Washington, D.C. 20016 Sundi Stein/Companion permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 13, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State May Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 2009 Lireneral Service L 22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., N.W. Wash. D.C. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Seps **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) as the burial-tran Due to (or as a consequence of) signed by the attending physician I be detached for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Year Month in the past 12 months? Day Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed To the Hospital or Attending Physician: The law requi within 24 hours after death.

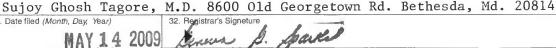
To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 shoult 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed: 1 □Yes 2 □No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

RoberT Montgom

31. Date filed (Month, Day, Year) 32. Registrar's Signeture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



MD

May 3, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene On One

		For State Registrar		Cer	tificate of I	Death		Reg. No.	009	1/310
Physic /Medi		1. Decedent's Name (First, Middle, Las Bonnie Jean Schon	·				2. Date of De Month 8		200 9 ° ar	3. Time of Death 10:45Р• м
Exami		4a. Facility Name (If not institution, give Holy Cross Hospit				Spring			inty of Death	
Funeral Director		217 70 3070	ex	rs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir July 6	, 1917	9. Birth Ohio	place (State or Foreign intry)
pu .		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Loc	ation					10d. Inside City Limits
e Maryla Ba-f sho	ector	Maryland Montgome		lver Spr	ing			10.000	of What Cou	1 □Yes 2 No
th with th 23a or 2	Funeral Director	3114 Gracefield R	oád, #313		10f. Zip Code 20904			Unite	ed Stat	
Dattilliore, Intal yiallo 4 14 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lipiny or other traumatic event, the Modical Evening must be ricitified at any high proper.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 □Yes 2 X No If Yes, Give Year or Dates:	1	□Yes 2 X No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	Spi		nite
vithin 72 hound.	Completed	15. Decedent's Ed (Specify only highest grade) Elementary/Secondary (0-12)		16a. Deced (Give life. L Homem		oation during most of work d)	king		of Business/Ir	ndustry
Idna A	To Be Co	17. Father's Name (First, Middle, Last) John James MacDon				18. Mother's Nam Myrtle B		⊥ , Maiden Sur	name)	
Midiry nd 2 shoul alth and M 27 is mar		19a. Informant's Name/Relationship (**	19b. Mailin 12106	g Address (Street East We	and Number or Rus	ral Route Numb d Drive	per, City or To Scott	wn, State, Z Sdale	, AZ 85259
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partition permit. Pages Department of Important: If it any Injury or o		21. Signature of Funeral Service Licel	ee tema	D6	Name and Address 13 d V.	Borgwardt r Mill Ro	Funera	l Home	e, PA e, Mar	ylənd 20705
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dS, Ruires that signed bid be deta		Part II. Other significant conditions of Atrial Fibrillati	contributing to death but not	resulting in the u	nderlying cause giv	ven in Part I.		tobacco use		the cause of death?
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an:] an:] tiffica tor, p	a)	25. Was case referred to medical				26. Place of Dea			12.00	
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DIVIS al or Atte s after deg il Directo	Certific	3 ☐ Suicide 6 ☐ Could not be determined		At home, farm, str	eet, factory, office		28f. Location City or To	(Street and Nown, State)	lumber or Ru	ural Route Number,
UNISION OT VITAI MED To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Medical (29a. Certifier 1X Certifying P (Check only one) 1 Medical Exa	hysician: To the best of my miner: On the basis of exa and manner stated.	knowledge, deat mination and/or in	h occurred at the to vestigation, in my	ime, date and place opinion, death occu	e, and due to thurred at the time	ne cause(s) a e, date and pl	nd manner as ace, and due	s stated. e to the cause(s)
To the common of	M	29b. Signature and title of certifier	working Mil)		8649		May	12, 2	
, , ,		30. Name and eddress of person who John Stuckey, M.I				er Spring	, Məryl	and 20	904	
S Regis	tate trar	31. Date filed (Month Pay Year) 4	2009 32. Registrar's S	Signature 6.	back					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 8 2009 2:22 P June Elizabeth Saunders 5 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 2209 N. Philadelphia Ave. Unit 109 Ocean City Worcester Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1/26/1929 Days Hours 1 □ M 2**X**□ F 80 OH 262-40-7007 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Show 1 XYes 2 No Director other traumatic event, the Medical Examiner marst be notified MD Ocean City Worcester 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 21842 USA 23a 2209 N. Philadelphia Ave. Unit 109 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 12. Was Decedent Ever in U.S. Armed Forces 72 hours after 1 □Yes 2 XNo If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify. ģ white 3 ☐ Widowed 4 💆 Divorced Year or Dates "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than. Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Seamstress marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fill and Mental h Be Olive Skinner Clarence Postle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21842 19a. Informant's Name/Relationship (Type. Print) Health an 2209 N. Philadelphia Ave. Unit 109, Ocean City MD Jasper Saunders / son item 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages 1
Department of H
Important: If iter
any Injury or oth 20a. Method of Disposition 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State Cape Henlopen Crem. 5/11/2009 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or fleart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Parti Immedime Cause (Final grs **Physician** ongeSTIVE disease or condition resulting in death) /Medical Due to (or as consequence of): Examiner rein my opATV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). the death certificate be executed the burial-transi Exami and that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, physician Physician/Medical signed by the attending I IF FEMALE 23c. If yes, outcome of pregnancy
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4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) P.0. Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 250No 24a. Was an autopsy performed Yes 2 2 No has 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification; To this te Hospital or Attending Phy: n 24 hours after death. ne Funeral Director: After this pletely filled in by the funeral di 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated To the I within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

State

BA 6

30. Name and address of pen

31. Date filed (Month, Day,

OHICE

Waldorf

who completed cause of death (Item 23a) (Type, Print)

AMANAM

Year)

OST

09-04051 Julie Scheffres

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Physician	-	23a. Part I. Enter the disease, of	or complication	s that caused	the death	. Do not enter t	ne mode of o	lying, s	uch as ca	rdiac or	respiratory a	rrest, shoo	ck, or heart	App	roximate Interval
Physician /Medical		failure. List only one caus	e on each line.											Bet	ween Onset and Death
xaminer	- 1	Immediate Cause (Final diseas	e a Met	hadon	e, fl	uoxetin	e, an	d /	-am1r	JOCT	onazer	am		_	
		or condition resulting in death)	Due to	(or as a cons	equence o	f): Intox	ICALI	OII							
	L.	Sequentially list conditions,	b.	for as a nons	end bender de	f).					_	_			
	miner	if any, leading to immediate cause. Enter Underlying Cause	e	(Ur dis it KUESS	ESCULIAN ALASE LA									-1	
0	- CG	(Disease or injury that initiated events resulting in death) Last		(or as a cons	equence o	f):	-								
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e be ysicii	ed	IF FEMALE:										234	I. Date of deli	ivery	
3760, ficate b g physic	N/	23b. Was decedent pregnant in		If yes, outco		nancy 2 Fe	tal death	3	Ectopic	pregnan	ncy		Month	Day	Year
certi	cial	past 12 months?	4	Pregnant a		oth	her (Specif)			, ,	,				
Box 687 ne death certific the attending	Physiciar	1 Yes 2 No 9 🗸 U	nknown 9	Unknown		• _ 0	inci (opeon)	· ·							
O. E at the c I by th tached	Ph	Part II. Other significant cond	itions contril	outing to deat	th but not r	esulting in the	inderlying c	ause gi	ven in Pa	rt I.	23e. Di	tobacco u	use contribute	e to the ca	use of death?
, P.O ires that the signed by	ģ	-9-1									1 🔲	res 2	No 3 🗸	Probably	4 Unknown
uires	Completed										24a. W	as an	24h. Wer	e autopsy	findings available
ords, w requir s been s should 1	ole										au	topsy		to comple	etion of cause of
Recol The law icate has	Ĕ										1 ✔ Ye	rformed? s 2 No		Yes	2 No
tal Rection: The certificate ector, page		25. Was case referred to medic	al				26	Place	of Death ((Check o	nly one)				
Vital ysician: his certifi director,	Be	examiner?	Hospital	1 Innati	ent 2 🗸	ER/Outpatien	3 DO	A I	Other:	Nursino	Home 5	Reside	nce 6 C	Other:	
F Vi Physical direction	ဥ	1 ✓ Yes 2 No	1 28	h-cameral .											
After After A	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month. Day, Year) 1 Natural 5 Pending 1 Natural 5														
Second contributing to death but not resulting in the underlying cause given in Part I. Second contributing to death but not resulting in the underlying cause given in Part I.									3-1						
ViS or A fler of in by	Seg 등로 등 3 Suicide 6 X Could not be be bounded thousand the suicide or									C.	28f. Locatio or Town	n (Street a n. State)	980 Fa	r Rural Ro Lrm Ha	oute Number, City aven Dr
illed Illed										Rockv	ille,	MD			
Hosp 24 ho Fune ely fi	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yea														
To the I within 2 To the I complet											se(s)				
To To	Mec	29b. Signature and title of certi		anne <u>r stated</u>			29c.	License	e number			29d.	Date signed	(Month, D	ay, Year)
									May	23, 2009)				
		Wolfente	meld	holl	2			٠.٠.١							
		30. Name and address of person					-	. –	te		24004				
		Margarita Korell MD.	Assista	nt Medica			enn Stre	et, Ba	altimore	e, MD 2	21201				
S	tate		0000	2. Registr	ar's Signa	par	11								
Regis	trar	WAY 26	2009	Enera	1 13	· Janas	1								

09-04201 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Austin Lee Tulley State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Rea No 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Time of Deat Medical Examiner Month Day May 26, 2009 Austin Lee Tulley 1540 hrs 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death St. Marys Hospital Leonardtown St. Mary's **Funeral** 5. Social Security Number 6. Sex 7. Age (in vrs. last hirthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) g. Birthplace (State or Director Foreign Maryland Country) Months Days Hours 218-83-3218 1 X M 2 F December 25, 2008 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Maryland St. Mary's Leonardtown 1 X Yes 2 No hours after death with the Maryland Director 10e. Street and Number notified at 10f. Zin Code 10g. Citizen of What Country 22367 Cedar Street 20650 USA items 23a Funeral 11. Mantal Status 12. Was Decedent Ever in U.S. pe 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, 1 X Never Married Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes Widowed Divorced If Yes, Give Year specify: White 4 Yes 2 x No specify: ģ 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 I nent of Health and Mental Hygiene. College (1-4 or 5+) event, the Medical marked other than Baltimore, MD 21215-0036 Never Worked 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nickolas Brian Tulley Brandy Lee Langley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 is a Nickolas Brian Tulley / Father 22367 Cedar Street Leonardtown, MD 20650 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State natory or other place) x Burial 2 Cremation 3 Removal from State permit. Pages
Department of
Important: I May 30, 2009 Leonardtown, Maryland Donation 5 Other Specify Charles Memorial Gardens gnature of Funeral Service Licen 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650 **Physician** 23a. Palt I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line /Medical Between Onset and Sudden infant death syndrome (SIDS) Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) executed Physician/Medical AMENDED 23a,27, perME, g893 7/20/09 TT X UNPENDED þ Completed

To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, certificate Be this Certification: To After within 24 hours after death, To the Funeral Director: completely filled in by the fi Medical

F FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow	nancy	23d. Date of de Month	elivery Day	Year			
art II. Other significant condition	s contributing to death but not	resulting in the underly	ing cause given in Part I.		prio	Probably ere autopsy for to comple	
5. Was case referred to medical examiner?			26.Place of Death (Chec	k only one)			
1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other Nurs	ing Home 5 Re	sidence 6	Other:	
7. Manner of Death 1 X Natural 5 Pending 2 Accident Investiga		28d. Describe hov	28d. Describe how injury occurred				
Suicide 6 Could no determin		ory, office building, etc.	28f. Location (Stre or Town, State	Street and Number or Rural Route Number, City State)			
9a. Certifier 1 ☐ Certifying Physical Check only 2 ✓ Medical Examine	cian: To the best of my knowle	dge, death occurred at tand/or investigation, in	he time, date and place, an my opinion, death occurred	d due to the cause(s at the time, date and) and manner as I place, and due	stated.	e(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Death

29d. Date signed (Month, Day, Year)

May 27, 2009

Registrar DHMH 17 Rev 1/2001 **OCME 2006**

State

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifie

Patricia Aronica-Pollak MD.

and manner stated

Assistant Medical Examiner

32 Registrar's Signat

			1 _ State	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2009 175							
		-	Registrar 1. Decedent's Name (First, Middle, Last)			Timouto or I		2. Date of Dea	ath	Year	3. Time of Death
	Physicia	_	Emmadale	D.		Twigg		Month May 1,			6:37 P M
Con	/Medic Examin		4a. Facility Name (If not institution, give street	t and number)		4b. City, Town, or	Location of Death		4c. Cou	nty of Death	
1				Center		berland			Alle		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. 1	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da		Cou	nplace (State or Foreign untry)
_	Director		216-22-7350 Usual Residence of Decedent	A 02	110.			04/17/	1927	Mary	yland
	yland now		10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	a-fst	ctor	MD Allegany			_		1 X Yes 2 No			
	or 28	Dire	10e. Street and Number			10f. Zip Code		10g. Citizen		intry?	
	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Modell Evaluation of the profiled at	Funeral Director	1327 LaFayette Av				1502		14.1	USA	iaan Indian
	items	nne	A A	Vas Decedent Ever in U. rmed Forces?	S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	Rican, etc.)	- 14. 1	Race - Amer Black, White	
36	rs aft	by F	T. A If	∐Yes 2M∏No Yes, Give ear or Dates:		1 □ Yes 2 🏋 No	Specify:		Spe	ecify:	hite
21215-0036	2 hou	Completed by	15. Decedent's Education	1	16a. Dece	dent's Usual Occup	ation	rina l	16b. Kind o	f Business/I	
215	thin 7 le. an "n	nple	(Specify only highest grade con Elementary/Secondary (0-12)	college (1-4or 5+)	life.	kind of work done of DO NOT use retired	i)	ang			
21	ed wii lygien ner th	Con	12		Γ	eacher's	Aide 18. Mother's Nam	- /First Middle		~	chools
and	be fiii ntal H ed ott	Be	17. Father's Name (First, Middle, Last) Elmer	Davi	a		Olive	e (riisi, iviidale,	waiden Sun	Pip	er
ž	hould id Me mark matic	ပ္	19a. Informant's Name/Relationship (Type. P			ng Address (Street		ral Route Numb	er. Citv or To		
≥	nd 2 s alth ar 27 ls r trau		Jesse L. Shipe, Sr.			0 Cresap					
ē,	s 1 ar		20a. Method of Disposition	20b. F		osition (Name of matory or other place		Date		on - City or T	
Ë	Page Tent c int: If		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removed 4 ☐ Donation 5 ☐ Other (Specify)	val from State		emorial P	i	72009	Cumbe	erland	, MD
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Model Eventury or items of the Model Eventury or other traumatic events.		21. Signature of Funeral Service Licenses	ms Fami	-		Home, P.A.				
<u> </u>	9 9 E P 9		Men & 10	ams		404 Decat				, MD	21502
			23a. Part 1 Enter the disease, or complication shock, or heart failure. List only one ca	ns that caused the deat use on each line.	h. Do not en	1	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition resulting in death)	Circles	15 0	hier					5 ANS
6	/Medical Examiner		resulting in addatiy	Due to (or as a conseq	uence of): U						
		-e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):						
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
oʻ	e exec an an rial-tr	Еха	resulting in death) Last	Due to (or as a conseq	uence of):						
68760,	rificate be executed ng physician and as the burial-transit	dical	d								
			IF FEMALE:								
Вох	eath certifi attending for use as	ian	in the past 12 months?	f yes, outcome of pregna I □ Live birth 2 □ Feta I □ Pregnant at time of o	ıl death 3	☐ Ectopic pregnand ☐ Other (specify) _	у		230.	Date of del Month	Day Year
o	that the de ned by the a detached f	Physician/M		Unknown	leati 51	Other (specify) _					
σ.	law requires that the death certif as been signed by the attending 2 should be detached for use as	y Ph	Part II. Other significant conditions contribu	iting to death but not res	ulting in the u	ınderlying cause giv	en in Part I.	23e. Did t	obacco use	contribute to	the cause of death?
rds	quires an sign uld be	od by						1 🗆	Yes 2 🗖 N	lo 3⊟Pr	robably 4 🗌 Unknown
တ္ထ	aw requii Is been s 2 should	plete						24a. Was auto		4b. Were au	utopsy findings available completion of cause of
œ e	The ate h	Completed							rmed? 2 2 No	death?	2 🗆 No
of Vital Records,	Physician: The law rthis certificate has ral director, page 2 s	Be	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only o	one)		
Ę	hysio this o		1 Yes 2 No Hospi	1 Inpatient 2			4 KN Nursing H	ome 5 ☐ Resi			cify)
	iing F I. After funera	1 Inpatient 2 EP/Outpatient 3 DOA Onto 4 Nursing Home 5 Residence 6 Other 27. Manner of Death 1 Natural 2 Accident 2 Accident 3 Suicide 4 Homicide 4 Ho								currea	
isi	Attending r death. sctor: After by the funer	icat	2 Accident investigation 3 Suicide 6 Could not be	8e. Place of Injury - At he	ome. farm. st		Tes Z INO	28f. Location (Street and N	umber or Re	ural Route Number,
	after Dire	ertii	4 ☐ Homicide determined	building, etc. (Special				City or To	wn, State)		
_	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier 1 CertifyIng Physicia (Check only 2 Medical Examiner:	n: To the best of my kno	owledge, dea	th occurred at the t	me, date and place	e, and due to the	cause(s) an	d manner a	s stated.
	he Hk in 24 he Fu	Medical	(Check only 2 Medical Examiner: one)	On the basis of examina and manner stated.	ation and/or i	investigation, in my	рыпіоп, aeath occu	irea at the time			
		Σ	29b. Signature and title of certifier						th, Day, Year)		
	2			D33280 May 2, 200							
	nrs		30. Name and address of person who comple						0.4.5.0.5		
	Sta	to	Sunil K. Gupta 31. Date filed (Manth, Day, Year)	M.D., 625 32. Registrar's Signa	Kent ature/	Avenue, (umberlan	a, MD 2	21502		
	Sta Registr		MAY 0 4 2009	32. Registrar's Signa	gard						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** ELIZABETH THOMAS В. May 8, 2009 6:44 Am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Nursing Grove Rehab Olney 1 Year | If Under 24 Hrs. Montgomery Brooke 8 8. Date of Birth (Month, Day, Ye July 30 Birthplace (State or Fore Country) Maryland If Under (State or Foreign **Funeral** 0,1911 Days Hours Months 1 ☐ M 2 💢 F 97 Director 213-28-6845 Usual Residence of Deceden death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ns 23a or 28a-f shormust be notified at 1 ☐ Yes 2 X No MD Montgomery Silver Spring Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20905 U.S.A. 15510 Holly Grove Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Item 27 Is marked other than "natural", or items other traumatic event, the Medical Examination Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or itel any injury or other traumatic event, the Medical Even 1 Never Married 2 Married Specify: Black 1 ☐ Yes 🏖 ☐ No Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montgomery Co Elementary/Secondary (0-12) College (1-4or 5+) Teacher's Aide 12th Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emma B. Stewart Richard N. Burkley ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2090519a. Informant's Name/Relationship (Type. Print) 15510 Holly Grove Rd, Silver Spring, MD Patricia Thomas (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from Sta Sandy Spring, MD Mutual Mem. Cem 5/13/09 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signature of Funeral Service 246 N. Washington St, Rockville, MD 20850 cations that caused the death D Approximate Interval Between Onset and Death 23a. Part 1. Enter the dis ase, or comshock, or heart failure. List on enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Senile Dementia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, aftending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ned by the a 1 🗆 Yes 2 **N**0 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Polymyaloma Rheumatic Completed 24b. Were autopsy findings available prior to completion of cause of death? Bullous Pemphigoid 24a. Was an autopsy performed? Yes 2 No this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) e Hospital or Attending P 24 hours after death. e Funeral Director: After t 28b. Time of 28c. Injury at Work? Aftert 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled in 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

ckson MD 3416 Olandwood Ct #200, Olney MD 20832

29d. Date signed (Month, Day, Year)

		1	For State Registrar	State of Mar	-	epartmer C <i>ertificat</i>			мептат ну	giene Reg. No.	2009	17522		
	Discolate	_	1. Decedent's Name (First, Middle, Las						2. Date of De Month	Day	Year	3. Time of Death		
	Physicia /Medic	al			Weasenf				May 19			3:15 P M		
	Examin	er	4a. Facility Name (If not institution, give			4b. City,		Location of Dea	ath	40.0	C+ 1			
المعي	F		49598 Airedale 5. Social Security Number 6. Se		(In yrs. last birth		r 1 Year		s. 8. Date of Bi	St. Mary's 9. Birthplace (State or Forei				
	Funeral Director			M 2□F	-	rs. Months	Days	Hours Mir	n. (Month, D October	ay, rear) 20 , 19		untry) Virginia		
	pe ,		Usual Residence of Decedent		On City Tayon	ar Lagation						10d. Inside City Limits		
	arylar show	5	10a. State 10b. County		Oc. City, Town		Ridge					1 ☐ Yes 2 ☑ No		
	the M	Director	Maryland St. M 10e. Street and Number		10g. Citizen of What Country?									
	with yard		49598 Airedale			USA								
	ms 2;	Funeral	11. Marital Status	12. Was Decedent Eve	er in U.S.	1 -	20680		(Specify Yes or Nerto Rican, etc.)	0- 1	4. Race - Ame Black, White	rican Indian,		
396	be filed within 72 hours after death with the Maryland that Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Evarine must be notified at	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1		1 □ Yes		Specify:	sito riidan, did.)	1	ite			
5-0036	72 hou	Completed	15. Decedent's Ed (Specify only highest grad	ucation	16a. l	Decedent's Usu	al Occupa	ation during most of w	orkina	16b. Kin	d of Business/	Industry		
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2	ed wi lygier her th		10			- Stea	INT T C		ame (First, Middle			mmenc		
ano	ev d c	Be	17. Father's Name (First, Middle, Last) Lake Vernon Weas	enforth				To. Modier's iv	Pearl 1					
Maryland	2 should be I and Mental is marked o raumatic eve	ဥ	19a. Informant's Name/Relationship (7		19b.	Mailing Addres	s (Street a	and Number or	Rural Route Num			Zip Code)		
	s 1 and 2 should of Health and Mer item 27 is marke other traumatic		Mary Agnes Weasen		1,0	598 Air	,		Ridge, 1					
5	Pages 1 ar nent of Hez ant: If item ury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of l	Disposition (Na v, crematory or ciendship	me of other plac Unite		Date 22, 2009		cation - City or			
	permit. Page Department o Important: If any Injury or once.	1	4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Ucen	4	Methodia	st Cemete 22. Name a		-	22, 2007	REG	ge, nary	Tand		
Ba	Imp any		Michael	Hardin	en)	Matt	ingley Box	-Gardine	r Funeral ardtown, M	Home,	P.A. 50			
7			23a. Part 1 Enter the disease, or comp shock, or heart failure. List only	olications that caused the	ne death. Do n	ot enter the mo	de of dyin	g, such as card	lac or respiratory	arrest,		Approximate Interval Between		
- Non	Physician		Immediate Cause (Final disease or condition	METAS		BLAD]	ER	CAN	cor			Onset and Death		
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58760,	ficate be executed physician and s the burial-transit			d										
68	rtificat ng phy as the	ledical												
Box	eath certifi attending for use as	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		3 ☐ Ectopic	pregnanc	у		23d. Date of delivery Month Day Y				
О.	he dea the at thed fo	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at t 9 ☐ Unknown		5 Other (s	specify) _				World			
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Ä	The law ate has page 2 s	mo								formed?	death?			
ita	sian: ertifica ctor, p	Bec	25. Was case referred to medical examiner?						Death (Check only	one)				
<u>></u>	Physician: The la r this certificate ha ral director, page 2	၉	1 Yes 2 TWO		t 2 ER/Out			4 LI Nursin	g Home 5 Re			ecify)		
n o	ding Ph h. After th funeral	ion:	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day,	/ 28b. T Year) lr	ime of ijury M	28c. Injur Wor	ryat k? Yes 2 ⊡No	28d. Describ	e how injur	y occurred			
isio	death death stor: / the f	icat	2 Accident investigation 3 Suicide 6 Could not be		v - At home, far			Yes Z INO	28f. Location	(Street an	d Number or F	Rural Route Number,		
Division of Vital	lor A after Direct	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)	, 55,	.,,			own, State				
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely illied in by the funeral director, page 2 should be detached for use as the burial-transit	Medical C	29a. Certifier 1 Certifying Pr (Check only one) 2 Medical Exar	nysician: To the best of niner: On the basis of and manner state	examination and	, death occurre d/or investigation	d at the ti on, in my o	me, date and pl opinion, death o	ace, and due to the	ne cause(s e, date and) and manner a d place, and du	as stated. e to the cause(s)		
	o the o the omple	Mec	29b. Signature and title of certifier	and mariner state		2	9c. Licens	se number		29d. Dat	te signed (Mor	nth, Day, Year)		
12 Cin MD D56096								5.	-20-0	79				
	1000		30. Name and address of person who	C. 6'LL	CHAM !	ASSOCIA	765	110	mjwoo	D	MD.	20636		
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar					,	· · · · · · · · · · · · · · · · · · ·				
	Regist	rar	MAY 20	7009	ana A									

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day **Physician** 2001 Wolford Cheryl /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CLEGNET If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Ye Aug 11, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Hours Months Days 1 M 2 F 214-46 382 1944 ΜD Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hyglene.
marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Count permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Menlar Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is the first in the routified any injury or other traumatic event, its the first in the matter or officed any injury or other traumatic event, its the first in the 1 □ ¥es 2 □ No WV Mineral Ridgeley Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Route 4 Box 758 26753 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: ò white 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Wanda Crabtree Miller Bernard Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) WV 26753 Route 4 Box 758 Ridgeley George Wolford husband 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Sogcify) Sunset Memorial Park 5/9/2009 MD Cumberland 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Finer S 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a ar I. En er he di Jase, ock, o haart fall re. L In rediate ause (Fi a disease or profition resulting in de th) Physician /Medical Due to (or as a consequence of): Examiner ovarien Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Exami burial-tran and Due to (or as a consequence of): Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the buria To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burit Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 I Unknown Part II. Other significant conditions contributing to death but not fesulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No 24a. Was an 2 No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 🔼 No P

☐ patient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D66430 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. Blanche Mariomatic 900 Setol Drive Combercap, MD 21702

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 11

2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Year 9 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** He15AM Mai 200 WATI KIRAN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGES DOCTORS COMMUNITY HOSPITAL LANHAM Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 💢 F 98 JUNE 30,1910 INDIA Director 233-43-8631 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it of Medical Evanipat must be rotified at once. 1 TYYes 2 □ No Director BOWIE PRINCE GEORGES 10g. Citizen of What Country? 10e. Street and Number 20716 U.S.A. 16010 EXCALIBUR RD. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: ASIAN INDIAN 1 ☐ Yes 2X No Specify: þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOME HOMEMAKER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DEVKINANDAN MITAL GOPT ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7605 QUICKSILVER CT., BOWIE, MD. 20720 NEERAJ BINDAL/GRANDSON 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) CHAMBERS CREMATORY 5-13-2009 RIVERDALE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 1/20 20737 5801 CLEVELAND AVE., RIVERDALE, MD. M00091 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final espirator Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Congestive if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner MIOCAR Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Vear Day in the past 12 months? 1 ☐ Yes 2 DNo 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 DHO funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide

Hospital or Attending Pl 24 hours after death. Funeral Director: After the filled in by the 24 hours a completely To the within 2.

State

Medical

29a. Certifier

(Check only

29b. Signature and title of certific

30. Name and address of person

and manner stated.

who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

mDD 60611

8118 Good Luckld, Lanham,

29d. Date signed (Month, Day, Year)

000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 24, 2009 **Physician** Wilson 7:08pm™ Lois /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WMHS--Frostburg Nursing & Rehab Ctr. Frostburg Allegany 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Apr 10, 1916 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ € 213-24-6598 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f sho MD Allegany Frostburg 1 □¥es 2 □ No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 48 Tarn Terrace 21532 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 □ 🖔 Specify: 3 □ Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 127 Is marked other than "n traumatic event Elementary/Secondary (0-12) College (1-4or 5+) White Oaks Bowling bar manager/office assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Gehrdes Theresa (Weidlick) Gehrdes ္က 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: if Item 27 Is any injury or other trau once. MD 21502 Georgette Appel daughter 11310 Drake Road SE Cumberland 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sunset Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/27/2009 Cumberland MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funer Septe Licen 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the diser se, or co p cations shock, or heart failu List on y one caus Immediate Cau e (Final disease or cov itton resulting in d ath) hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Onset and Death **Physician** 2 years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine or Attending Physicien: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 **N**o 1 ☐ Yes 2 No 1 ☐ Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 | Residence 6 | Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 28c. Injury at Work? 1. Natural
2 Accident 5 Pending n 24 hours after death.

e Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Hosp within 24 ho To the Fune (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) worreckflin MD 10055325 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 925 Bishop Walsh Rd Cumberland MD21502 32 Registrar's Signature WONSOCK SHEW MD925

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

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			For State	State of Ma	aryiani		parimen <i>ertificati</i>				g. No. 2	nnA	17526	
			Registrar 1. Decedent's Name (First, Middle, La	et)			erincan	e oi D		2. Date of Death		00/2	3. Time of Death	
	Physicia /Medic		John Har	niltan	8	110				Month	Bay 30	2009	22:30M	
	Examin		4a. Facility Name (If not institution, give			4		Town, or L even:	ocation of Death	(unty of Death 1timo		
Ar M			1738 Greenspr: 5. Social Security Number 6. S		e (In yrs. I	f Under 24 Hrs.	8. Date of Birth		9. Birth	nplace (State or Foreign				
	Funeral Director			M 2□F	10		Months	(Month, Day,	190		mford, CT			
10a. State 10b. County 10c. City, Town or Location												10d. Inside City Limits		
											1 □Yes 2 <mark>X</mark> No			
	a or 28	Funeral Director	10e. Street and Number 1738 Greenspr	ing Vall	ev R	oad	10f. Zip	Code 1153			•	g. Citizen of What Country? U.S.A.		
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ary	S E E	-	19a. Informant's Name/Relationship	(Type. Print)			-						Zip Code) 2115 3	
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altimore, Maryland	ges 1 and it of Healt If item 27 or other		20a. Method of Disposition 1 Durial 2 Cremation 3 D	Removal from State	20b. P	lace of Di	sposition (Nar rematory or o	ne of other place)	pel _{06/0}	Date 2		tion - City or -		
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Balt	permit. Page Department of Important: If any injury or ance.		21. Signature of Funeral Service Lice	NIIX			8800 Ha:	rror	a ka. P	el & Cre arkville	≥. M	ion S D 212	erviœs 34	
			23a. Part 1. Enter the disease, or conshock, or heart failure. List only	plications that cause	d the deatl	n. Do not	enter the mod	de of dying	such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death	
200	Physician		Immediate Cause (Final disease or condition	Mn	ه ده	odi	al.	Int	archo	slass			Ihour	
	/Medical Examiner		resulting in death)	Due to (or as	a conseq	uence of):	Δ .	A	N -	. 100				
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•	te be executed ysician and e burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
oʻ	be executed ician and burial-transit		resulting in death) Last	Due to (or as	a conseq	uence of):								
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. 68	ertificate ling phys e as the	Physician/Medi	IF FEMALE:		,									
Вох	eath cer attendin for use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Feta	I death	3 Ectopic p				230	 d. Date of del Month 	Day Year	
P.O.	at the de by the	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant : 9 ☐ Unknown	at time of t	ream	5 ☐ Other (s	респу)						
σ.	that the post of t		Part II. Other significant conditions	contributing to death I	but not res	ulting in th	e underlying o	cause giver	in Part I.	23e. Did tob	acco use	contribute to	the cause of death?	
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ita	lan: rtifica ctor, p	Be C	25. Was case referred to medical						26. Place of Dea	th (Check only on				
}	nysic nis ce i direc	To E	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpat	ient 2	ER/Outp	atient 3 □ D	OA Other	4 Nursing F	lome 5 Reside	ence 6 [∃Other (Sρ€	ecify)	
0	ding Ph h. After th funeral		27. Manuer of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inj (Month, D		28b. Tin Inju	iry	28c. Injury Work?		28d. Describe ho	w injury o	occurred		
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Division	or At after o Direc	Certification:	4 Homicide determine	200. Flace Util	etc. <i>(Speci</i>	fy)	, street, lactor	y, office		City or Town	n, State)	vumber or re	urar route rumber,	
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	To the Pwithin 24 To the Foomplet	Medical	one)	and manner s	tated.			c. License					th, Day, Year)	
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CERTIFICATE

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CERTIFICATE #

2009-26656

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene2009Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Day :45 AM **Physician** OV 200 man /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** izabeth mor If Under 1 Year 8. Date of Birth (Month, Day, Birthplace (State or Foreign
 Country) (In yrs. last birthday) Social Security Number Year) **Funeral** Months Days Hours Min. Jan. 6, West Virginia 1915 94 204-03-9075 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State or 28a-f show ral", or items 23a or 28a-f show 1 ☐ Yes 2 No Baltimore Funeral Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A 21227 2909 Georgia Avenue Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hyglene.
ant: If item 27 is marked other than "natural", or items 23 ary or other traumatic event, the Modical Examination untal Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. White Never Married 2 Married 1 ☐ Yes 2/XNo If Yes, Give 1 □Yes XXNo Baltimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Own home Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alcinda Norris Columbus Apple Mary Julius ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2909 Georgia Ave., Baltimore, MD 21227 Elizabeth A. Davis/Niece 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 ☐ Burial XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 6/6/2009 Hagerstown, MD 22. Name and Address of Facility Helsley-Johnson Funeral Home, Inc. 21. Signature of Funeral Service Licensee M00522 95 Union St. Berkeley Springs, WV 25411-1855
not enter the mode of dying, such as cardiac or respiratory arrest,
Approximate Interval Between Approximate interval Between 23a. Part 1. Enter the isease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Da Onset and Death Immediate Cause (Final SIGNS tas eivee **Physician** disease or condition resulting in death) /Medical Due to (or may Examiner nabro Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending pl 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 3 Probably 4 ☐ Unknown olisorder 2 X No After this certificate has been s funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ension autopsy performed? 2 No 2 🗆 No 1 ☐ Yes Urom 1 ☐ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 42 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No Hospital: 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Natural
Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b, Signature and title of certifier

State Registrar 30, Name and address of person who completed,

31. Date filed (Morth, Day, Year)

DHMH 17 Rev 1/2001

se of death (Item 23a) (Type, Print)

S-97807 32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month BREDBENNER **Physician** 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner CHARLES LA PLATA CIVISTA MEDICAL CENTER 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year)
OCT . 14, 1951 If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 XM 2 ☐ F GERMANY 57 Director 213-62-7949 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show show XXes 2 □ No LA PLATA Director CHARLES MD Pages 1 and 2 should be filed within 72 hours after death with the nent of Health and Mental Hygiene. 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number ral", or items 23a or U. S. A. 20646 210 WILLIAMSBURG CIRCLE Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Armed Forces : 1√2 Yes 2 □ No If Yes, Give Year or Dates: 170 - 102 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify <u>ک</u> WHITE 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, It a Mudical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U. S. AIR FORCE COLONEL LT. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GEORGINA TRUNK JOSEPH BREDBENNER ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 210 WILLIAMSBURG CIRCLE LA PLATA, MD 20646 LILA BREDBENNER/SPOUSE MAY Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State ALEXANDRIA, VA METRO. CREMATORY 28,2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 21. Signature of Funeral Service M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final omin Physician resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician the IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Live birth 2 Fetal death
Pregnant at time of death Month 5 ☐ Other (specify) ned by the a 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed 1 Yes 2 No 2 No 1 ☐ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To After this 27. Manner of Death Natural 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

ne Funeral Director: A
pletely filled in by the fi 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 141 leted cause of death (Item 23a) (Type, Print) 30. Name and address of person who com 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

Physician /Medical Examiner
Funeral

1 - For State Registrar

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Maryland			Karen Yam IT	Muchton	10211 0				
	s 1 and 3 if Health Item 27 other tra		200 Mathad of Disagnition	170	Place of Disposition (attell Koad		own, MD	
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Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licens	see	22. Name	and Address of Facility	aughn C. (Sveene Fur	reval service
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	hou hou uner ly fill		29a. Certifier (Check only 2 Medical Exam	ysician: To the best of my kn	owledge, death occur	ed at the time, date and place	e, and due to the caus	se(s) and manner as st	ated.
	n 24 n 24 n 54 n 6 F	edical	one)	iner: On the basis of examin and manner slated.	ation and/or investiga	ion, in my opinion, death occ	urred at the time, date	and place, and due to	the cause(s)
	To the Hospital or Att within 24 hours efter de To the Funeral Direct completely filled in by t	ž	29b. Signature and title of certifier			29c. License number	29d.	. Date signed (Month,	Day, Year)
				× =		7375	12	May 28	7009
	Λ.		30 Name and address of sersest.s.	populated cause of death (the	m 22a) /Tyras Driet)	Λ 2 [3	1 7	1410A CO	, 0001
	ITA		30. Name and address of person who c	1		Nay St-	Qoid 1	May 28	-117/
	C1		31. Date filed (Month, Day, Year)	32. Begistrar's Sign		1/4 My 31-	Licialenz	Iam MIN	2112
Table 1	Sta	te		January State of Sign					

DHMH 17 Rev 1/2001

Registrar

Division of Vital Records, P.O. Box 68760,

09-04179 Audrey Bryant Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 17531

		I- For State Registrar		Cei	rtificate d	of Dea	th				eg. No.				
Physicia		Decedent's Name (First, Middle)													
ledical Exami	ner	Audrey	Bryan	t					N	May 26, 2	:009		0135 hrs		
		4a. Facility Name (if not institution				4b. City	, Town, or Lo	ocation of	Death			ty of Death			
		4000 Oaklawn Road				Fort	Washing	ton			Prince	George	e's		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Un	der 1 Year	If Under	24Hrs. 8	3. Date of Bi	rth (MM/DD/YY	YY) 9. Bir	thplace (State or Foreign		
Director				48		Mon	ths Days	Hours	Min.	Oct. 2	27, 196	n Co	rthplace (State or Foreign ountry) DC		
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Maryland 28a-f show datonce.	Director	10e. Street and Number		10f. Zip Code 10g								Citizen of What Country?			
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death with the Maryland or items 23a or 28a-f sho	폡	11. Marital Status	12. Was De	cedent Ever in U			dent of Hisp						rican Indian, Black,		
eath item	Funeral	1 Never Married 2 X M	larried Armed F	orces?	l lf	Yes, spe	cify Cuban,	Mexican,	Puerto Rio	can, etc.)	"	hite, etc.			
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with with her t	E	17. Father's Name (First, Middle	Last)		beed	1109				irst, Middle,	Maiden Surna				
215-0036 be filed within 7 ntal Hygiene. rked other than	9							Fran		Bonhar	n				
212 ould be Menta mark c even	9	Herbert E. Cr 19a. Informant's Name/Relations	awley_		19b. Mail	ina Addre	ess (Street				mber, City or	Town, Stat	te, Zip Code)		
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Page ent o		4 Donation 5 Other S			Veter	ans (Cemete	ry	6-4-	-2009	Che1	Cheltenham, Md.			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours af Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural injury or other traumatic event, the Medical Examin		21. Sanature of Funeral Service			22	Name a	nd Address	of Facility	ral i	Home (of Mary	land			
		10 Shrun D	Sugate	5	14	308	Suitla	and R	ld.	Suit1a	and, Md	l. 201	746		
Physician		23a. Part I. Enter the disease, or	r complications that	caused the death	. Do not ente	r the mod	le of dying, s	such as ca	ardiac or re	espiratory a	rrest, shock, o	r heart	Approximate Interval Between Onset and		
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387 rtific ing p	an/	23b. Was decedent pregnant in t past 12 months?	Live	birth	_	Fetal dea	ith 3	Ectopic	pregnanc	су	Mon	th	Day Year		
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Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been seled in by the funeral director, page 2 should I	Be (25. Was case referred to medic examiner?			_			of Death Other	(Check or						
Vit hysic this dire	.0	1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpati					Home 5			ner: Scene		
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75 5 5 5 N	May 26, 2009 0109 hrs 2 Accident 3 Suicide 4 Homicide Homicide May 26, 2009 0109 hrs 2 Suicide 4 Homicide Homicide Homicide May 26, 2009 0109 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 4000 Oaklawn Road, Fort Washington, MD										Rural Route Number, City				
Div talo rs afi led i	or Town, State) 4 W Homicide determined (Specify) Single Family Home or Town, State) 4000 Oaklawn Road, Fort Washington, MD									ngton, MD					
Div Hospital or 24 hours afte Funeral Dir ttely filled in															
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	ica	(Check only certifying Physician: To the best of my knowledge, death occurred at the line, date and place, and due to the cause(s) and market declared at the line, date and place, and due to the cause(s) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)													
To the complet	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)													
	=	O.C.M.E. May 26, 2009													
		Card	Carol Hallan												
		30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201													
		Carol Allan, MD As	ssistant Medica	l Examiner	111 Pen	n Stree	et, Baltimo	ore, MD	21201						
S	tate	31. Date filed (Month, Day, Year) 32	Registrar's Signa	ture		P								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 7532 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2009 6:45 A May 31, Charles Evans Beall 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Harford Bel Air Upper Chesapeake Medical Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number Hours 1 M 2 □ F Months Days Feb. 14, 1945 Maryland 64 215-42-0548 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 1 ☐ Yes 2 STNo Whiteford Harford Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21160 USA 1564 Kerr Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 XNo Specify Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pet Food Distributor Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alexander Evans Beall Margaret Louise Bailey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1564 Kerr Road, Whiteford, MD 21160 Barbara A. Beall / Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Forest Hill, Maryland 6-4-09 4 ☐ Donation 5 ☐ Other (Specify) Centre U.M.C. Cem. 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, MD 21014 Approximate Interval Between Poset and Death On Months Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final use disease or condition resulting in death) Due to (or as a consequence of):

Physician /Medical Examiner Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural naying and Injury or other traumatic event, it is Me Jicall ance.

Physician

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show

Director

Funeral

2

Completed

Be

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2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

/Medical

physician and the burial-trans attending physician for use as the burial neral Director: After this certificate has been signed by the filled in by the funeral director, page 2 should be detached 24 hours after deatle Funeral Director:

Ocall Charles Ou M24
Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to minieurate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	23d. Date of delivery Month Day Year						
Part II. Other significant conditions co	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 3						
		24a. Was an autopsy performed? 1 □ Yes 2 □ No						
25. Was case referred to medical	26. Place of Dec	ath (Check only one)						
examiner? 1 ☐ Yes 2 2 10	Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	lome 5 Residence 6 Other (Specify)						
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of lnjury 28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injury occurred						
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier 1. Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my knowledge, death occurred at the time, date and plac niner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)						

29c. License number

754841

29d. Date signed (Month, Day, Year)

09

State Registrar

Medical Certification: To

31. Date filed (Month, Day, Year) JUN 0 2 2009

Ashkan

29b. Signature and title of certified

Bahrani, M.D., 602 S. Atwood Road, Suite 200, Bel Air, MD 21014 82. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 2 To the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 320 AM Day Year **Physician** 3 2009 Anthony R. Cimino, Sr 4a. Facility Name (If not institution, give street and number) 0 /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore FRANKLIN SQUEETE HOSPITAL CENTER Rosedalt If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. 1√2 M 2 □ F Months Days Hours 218-28-9964 76 Director Dec. 4, 1932 Md Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Evantine must be multiled a once. 1 ☐Yes 2 ☐ No **Funeral Directon** MD Baltimore Nottingham 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 14 Juliet Lane, #204 21236 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, GiveX X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify.White Specify: <u>Ş</u> 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Correctional Officer Balto City Jail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Robert Cimino Rosalie Mileo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa Cimino (wife) Juliet Lane, Nottingham, Md. 21236 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery June 2,2009 Baltimore, Md. 22. Name and Address of Facility Schimunek Funeral Home, Inc. 21. Signature of Funeral Service Licensee Bucin 9705 Belair Rd., Nottingham, Md. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Arrhythmia **Physician** Fatal /Medical Due to (or as a consequence of): **Examiner** DISeas ArTery Atherosclerotic COSONGRY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hypertension burial-tran Due to (or as a consequence of): attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) signed by the a 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 ☐No 24a. Was an autopsy performed 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician: The law requires that the death certificate be executed s after death.

I Director: After this of in by the funeral d

within 24 hours a

the

Medical

State Registrar

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

054428

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause death (Item 23a) (Type, Print)

B. PIPKIN 9000 FRANKLIN Square DR Balto ind OR MIChael

31. Date filed (Month, Day, Year)

JUN 0 2 2009

32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May 29°, **Physician** 2009 Aleksandra Cipkus 1:15P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore 706 Woodland Drive 8. Date of Birth (Month, Day, Year, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🗙 F **Director** 216-34-4103 87 APR 25. 1922 Lithuania Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location show ir than "natural", or items 23a or 28a-f sho 1 □Yes X No Director MD Baltimore Relay 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 706 Woodland Drive 21227 USA Funeral filed within 72 hours after death 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: ð White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry alth and Mental Hygiene.
27 is marked other than "
r traumatic event, Its Men College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Unk. Laucevicius Kaze Unk. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once. Alfonsas Cipkus, husband 706 Woodland Drive Relay, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 05/30/09 Baltimore, MD 22. Name and Address of Facility Cremation Society of MD, Inc. 21. Signature of Funeral Service Licensee George MacNabb Heory 299 Frederick Road 21228 Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Billiary Carcinoma 2425 /Medical Due to (or as a consequence of): Examiner Hy pertension 1544 Sequentially list conditions, if any, leading to immediate cause. Erner underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ŧ, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit plaheles mellitu Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D30494 512912009 esaok nESAIM

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State Registrar 716 Maiden Chaicelane Calensville MD VILLE

31. Date filed (Month, Pay, Year)

32. Redistrar's Signature

33. Redistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(DESA/MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Curbean Bernard Inomas 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Randallstown lasons trospice—North west If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day) **Funeral** Year) Days Hours 1**X** M 2□ F Months 20.26.0374 Yrs Director 10 10/04 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show d 2 should be filed within 72 hours after death with the Maryla th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-4 shov traumatic event, the Medical Exanism entert by trefficed as Howard 1 ☐ Yes 2 No Director Columbia 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Stallion Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 4 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental H Important: If Item 27 Is marked oth any lijury or other traumatic event 9008. Cabean Wille 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21045 19a. Informant's Name/Relationship (Type. Print) ColumbiaND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mings Mills MD 06/05/09 Garrison torest 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Janann C. Greene Funeral SVO 21. Signature of Funeral Pervice Licensee rty Road Kandaystown MD 21133 23a. Part 1. Enter the d sease, or complications that caused the death. shock, or he irt failure. List only one cause on each line. Do not enter the mode of dying, su has cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (disease or condition resulting in death) **Physician** Due to r as a consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine -transit The law requires that the death certificate be executed and g physician are the burial-t Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending ph IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) detached 9 Unknown 9 Unknown signed by 1 1 be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖟 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? After this certificate 1 ☐ Yes 2 🗷 No 1 ∐Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 ☐ Yes 2 🗷 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Within 24 hours arier co.

To the Funeral Director: Aff 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number completed cause of death (Item 23a) (Type, Print)

h Button 2835 Smith Ave Suito 203 Baltimore. MD 21209 30. Name and address of person who Paistrar's Signature 31. Date filed (Month State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** 2009 21105 Arthur Bryan Cain MAY /Medical 4c. County of Death N/A 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Union Memorial Hospital If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country) 1957 Maryland 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** 1 → M 2 □ F 514-72-7326 Sept. Director 51 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Baltimore 10d. Inside City Limits 10b. County 10a. State N/A Maryland Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21239 1219 Silverthorne Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 No Black 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes XXNo Specify: If Yes. Give Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Operations Manager Verizon Years 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be Katherine Edmonds Moses Cain ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2780319a. Informant's Name/Relationship (Type. Print) 705 Mayfair Drive Rocky Mount, North Carolina Moses Cain/ Father 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Greenmount Cemeter 6/5/09 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, Md 21215 21. Signature of Funeral Service Lipes rure 23a. Part F. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, effect, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final · DISSEMINATED INTRAVASCULAR COAGULATION 4 days **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner FAILURE LIVER e squartially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed BACTEREMIA STAPHYLOCOCCAL sician and burial-trans Due to (or as a consequence of): (51 years) physician s the burial P.O. Box 68760 Litelona SICKLE CELL DISEASE Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Inknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? certificate 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Inpatient 2 ER/Outpatient 3 DOA Certification: To this After this funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

Ne Funeral virector. A pletely filled in by the fi fter death. 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the dead of the 29a. Certifier Medical (Check only and manner stated. within 2 the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier El-Maronche M.D. AT 2438946 31,2009

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State Registrar

DHMH 17 Rev 1/2001

EL-MADUSITE, M.D. UNION MEMORIAL HOSPITAL, MD 21218

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUN 0 2 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Day Year Physician LOUIS CAPLAN 9:30 May 2009 31 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore
Hinder 1 Year | If Under 24 Hrs N/A 5. Social Security Number O Sex Baltimore Birthplace (State or Foreign Country)
 MD Age (In yrs. last birthday) **Funeral** 220-18-9288 Months Days 04/04/1926 1 X M 2 □ F Hours Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City. Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Operatment of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hijury or other traumatic event, it of action is aminer must be notified at 1 □Yes 2 No Director BALTIMORE REISTERSTOWN MD 10a. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23 RED MILE COURT 21136 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 X Never Married 2 ☐ Married WHITE Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) SOCIAL SECURITY Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATION SUPERVISOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CAPLAN RUSHAWITZ ISRAEL GOLDA 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SARAH KAREN / SISTER 9305 GROFFS MILL DR., OWINGS MILLS, MD 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition TIFERETH TORACE PANSHE SFARD CONGREGATION 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/01/2009 ROSEDALE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE. MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 3 days **Physician** Due to (or as a consequence of): disease or condition resulting in death) Pricumonia /Medical Examiner Due to (or as a consequence ot): Perito need short placement 1 month if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Parkinsons Disco and Due to (or as a consequence of): Box 68760, signed by the attending physician ا be detached for use as the المنابع certificate be Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) □Yes 2□No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Accident Completed 24b. Were autopsy findings available prior to completion of cause of I or Attending Physician: The law after death.
Director: After this certificate has I autopsy 1 ☐Yes 2 ☐No 1 ☐ Yes 2 🗷 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊠No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

AMAR MANGALAPUDE

Am Ma

Sinai Hospital of Baltimore 2401 west Buredere Ave 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

MD

RCS 000

Nlay 31, 2009

MO 21215

Baltimore,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Ruth V. Cockey Month Day **Physician** May 29, 2009 8:05 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 3510 Chestnut Avenue Baltimore If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M Yrs. 214-22-9281 MD Director 82 Dec 16, 1926 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, It a Madical Examiner must be notified at 1. Yes 2 No Director MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3510 Chestnut Avenue 21211 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 72 hours after 1 ∐Yes 2 MYo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2XX Maryland 21215-0036 Specify. White Specify: ģ ₩Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ene. than "I Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper GC Murphy 9th permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other i any Injury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Streeks Loretta Bowen ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Carol Boggs (Daughter) Baltimore, MD 21211 3510 Chestnut Avenue Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition MXBurial 2 Cremation 3 Removal from State Lorraine Park 06/02/2009 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funcial Service 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Balto, MD 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Crebes Vascol disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Duri to (or as a consequence of) physician and s the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) signed by the a d be detached for 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b autopsy performed?

1 □ Yes 2 □ No certificate 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? B 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Hospital or Attending

Registrar

DHMH 17 Rev 1/2001

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

and manner stated

Rosenthin 608 Edgevall Road WD

	Please Type or Prin	aryland / Depa			-	-	lible.					
	1 _ State		rtificate of D			, No. 2	000	17	52			
	Registrar		tinoate of L	- Catir	2. Date of Death	, NO.	UUJ	3. Time of	Death			
an	Decedent's Name (First, Middle, Last)				Month	Day	Year	354	PM			
al	ETHEL CARTER				5	24	2009	221	F 101			
er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or			4c. Coun	ty of Death					
	UNIVERSITY of MAYIND MEDI	est Center	BALT	more,	MD							
		e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	(ear)	9. Birthp	place (State o	or Foreign			
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	Usual Residence of Decedent											
	10a. State 10b. County	10c. City, Town or Loc	cation				1	0d. Inside Ci	ity Limits			
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ecl.	MD Prince Georges 10e. Street and Number	CITICOII	10f. Zip Code		100	a. Citizen o	f What Cour	ntry?				
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ā	6808 Clinton Manor Dr.		2073			US						
ne	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S. 13. V	Was Decedent of Hi f Yes, specify Cubar	spanic Origin? (Spo n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ace - Amerio lack, White,					
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9	3 ☐ Widowed 4 ☑ Divorced Year or Dates:					Opec	В.	lack				
je j	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ient's Usual Occupa	ition		6b. Kind of	Business/In	dustry				
ם	Elementary/Secondary (0-12) College (1-4or 5	`life. [DO NOT use retired,	ing most of work	, ig							
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Be Completed by Funeral Director	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, Ma	aiden Surna	ame)					
To B	unknown			Mattie S	Sutton							
F	19a. Informant's Name/Relationship (Type. Print)	10h Mailin	ng Address (Street a			City or Tow	ın. State. Zir	Code)				
			5									
	Michael Carter-Son		Donne 11		Foresty		n - City or To					
	20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispos cemetery, cren	natory or other place	e)	Jale 2	JC. LOCATION	ii - Oity Or 10	JWII, Olalo				
	4 □ Donation 5 □ Other (Specify)	Cedar Woo	ds Cemete	ry 5-30	-2009 He	ertfo	rd, NO	3.				
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home of Maryland											
	Marshall's Funeral Home of Maryland 4308 Suitland Rd. Suitland, MD. 20746											
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,											
	shock, or heart failure. List only one cause on each line.											
) I	Immediate Cause (Final disease or condition	C Shock										
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Ñ					1 □Yes 3	No	1 ☐ Yes	2 □No				

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Medical Examination and indeed once.

Baltimore, Maryland 21215-0036

Be Comp Medical Certification: To

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

25. Was case referred to medical examiner?

examiner?

27. Manner of Death

1X Natural

2 Accident

3 🗌 Suicide

29a. Certifier (Check only one)

4 - Homicide

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RYAN ANSOLO 22 South

and manner stated

1 Inpatient

28a. Date of Injury (Month, Day, Year)

2 ER/Outpatient 3 DOA

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital:

5 Pending investigation

6 Could not be determined

32. Registrar's Signature

Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number \$\beta 22054\$

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

5/24/09

South Greene St. Buckinere, MD

Baltimore, Maryland 21215-0036

and Inc Physician: The law requires that the death certificate he executed
oraning in plantar. The last force of an are detail continuate be executed on after this certificate has been signed by the attending physician and the fineral director mana? Should be detached for use as the burial-transit

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Examine	er I	The Johns			<i>31)</i>		Baltin			•		ltimore		
Funeral		5. Social Security N			Age (In yrs. la	ast birthday)	If Under Months		If Under 24 Hrs. Hours Min.	8. Date of Bir	rth		hplace (State or Foreign	
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and M s mar		19a. Informant's N	ame/Relations	hip (Type. Print)		i	_		nd Number or R					
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hysician Medical xaminer	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									Onset and Death			
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nding use a	Physician/M	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 9 ☐ Unknown	months?	23c. If yes, outco 1	death 3	Ectopic p Other (sp				23d. Date of delivery Month Day Year				
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	ertification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	investi 6 Could determ	not be 28e. Place o	f injury - At ho j, etc. <i>(Specit</i>)		M eet, factory		∕es 2 □ No		(Street and own, State)	d Number or R	tural Route Number,	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** ISMAIL DIN MOHAMMED 1:18 6 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GROVE ADVENTIST SHADY HOSP ROCKVILLE MONTGOMER 8. Date of Birth (Month, Day, MAR 26 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Hours Year BURMA Director Usual Residence of Deceden 10d. Inside City Limits 10a. State 10b, County 10c. City, Town or Location 28a-f show ed other than "natural", or items 23a or 28a-f shovevent, the Madical Examinar must be notified at GERMANTOWN 1 Yes 2 □ No MD MONTGOMER Director 10e. Street and Number 10g. Citizen of What Country? 18889 20874 WARING STATION U.S.A. 'natural", or items 23a Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑No Specify: ASIAN ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n: any injury or other traumatic event, Ite Madic once. CARPGT COMP. Elementary/Secondary (0-12) College (1-4or 5+) MANGER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ROSHAN KHAIR-UN-NISSA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) FREDERICK MO DIN 21704 20c. Location - City or Town, State 20a. Method of Disposition 30, 2009 FREDENR 12 Burial 2 ☐ Cremation 3 ☐ Removal from State FIRDOUS GARDON 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Jan Ko FREDGRUR MO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BRADYCARDLE **Physician** disease or condition resulting in death) /Medical Examiner CARDIAMYOPAT Sequentially list conditions Physician/Medical Examiner than the cause. Enter Underlying Cause. (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760. the for use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month P.O. 1 Tyes 2 TNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ò 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 performe 2 No 2 No 1 □ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No □ Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Magner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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DHMH 17 Rev 1/2001

Registrar

Ball

(Month, Day, Year)

Joseph

16220 FREDERICA

32. Registrar's Signature

213 GATUTUSBURG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Betty June Dull 8:57 P. M May 30 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🕱 F Months 239 38 7024 Director Maryland 10/06/1927 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 Is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Micdical Examinar must be notified at **Funeral Director** 1 ☐ Yes 2 X No Maryland Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 376 North Drive 21146 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Completed by Specify 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Assistant Homecare 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Garland Murphy Trecia Thompson ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Y. Owen / Daughter 376 North Drive Severna Park, Maryland 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 06/03/2009 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 Fart 1. Enter the disease, of plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List ally one cause in each line. 23a. Fart 1. Enter the disease, Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** day /Medical Due to (or as a consequence of): **Examiner** 6 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, Physician/Medical If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 ∰Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ⊡ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 🗗 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year)

P.O. Division of Vital Records.

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State Registrar 29b. Signature and title of certifier

Hung Davis

31. Date filed (Month, Day, Year) 32. Registrar's Signature

200 Medical Parkway

air 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D53111

Annapolis, Maryland 21401

09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 29 Day Physician 2009 May 12:45P M Elizabeth DeVincent /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Marley Neck Health & Rehabilitation Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, Year)
June 28,1924 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 7. Age (In vrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Days Months 1 ☐ M 2 🗡 F Hours MD 216-16-3572 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c City Town or Location 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No MD Director Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 879 Brighton Place 21061 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2\text{\text{M}} No If Yes, Give Year or Dates: 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify White 21215-0036 9 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Department of Health and Mental Hygis Important: If item 27 Is marked other injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be pe Carl Bauer Irene Kohl Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Diana M. Stratton/Daughter 1589 Long Point Road Pasadena MD 21122 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition June 1 Burial 2 □ Cremation 3 ☐Removal from State 2009 Brooklyn, MD Cedar Hill Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation permit. 21. Signature of Funeral Service Licensee Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 MO1357 Approximate Interval Between Onset and Death 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, the intialiure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) LARS **Physician** END-STAGE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any. leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed Due to (or as a consequence of) 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1☐ Yes 2 No 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an HYPERTINSION page 2 s autopsy performed? 1□ Yes 2 No Division or Vital Hospital or Attending Physician; 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 3□ DOA 1 ☐ Inpatient 2 ☐ ER/Outpatient Certification: To this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 24 hours after death.

• Funeral Director;

• Stetely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the cause(s) and manner as stated. 29a. Certifier Medical To the Hosp within 24 hou To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 LINDEN AVENUE-BALTIMORE MD -827 M.D. Begistrar's Signature 31. Date filed (Month, Day, 'Year)

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State Registrar

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician Laura Rose Emminizer 1 2009 10:30 A.M June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Manor Care - Ruxton Towson Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Balt., Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 M 20 F 94 213-05-5001 Director 5/16/1915 Usual Residence of Decedent filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it is worlden Examinate in the Model. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Funeral Director Cockeysville 1 ☐ Yes 2 No 10g. Citizen of What Country? United States of America 10f. Zip Code 1 Stillway Court 21030 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 □No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 ☑ No Specify: White Specify: 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Gunther Eva M. Baier ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Eva C. Foti/ daughter 1 Stillway Court Cockeysville, Maryland 21030 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens 20c. Location - City or Town, State 20a. Method of Disposition Date June 4, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2009 Signature of Fineral Service Licensee Peaceful Alternatives Funeral & Cremation Ctr., P. A 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final omplications **Physician** Years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Lius to (or se a consequence of) The law requires that the death certificate be executed and burial-tran resulting in death) Last Due to (or as a consequence of): physician Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown is been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page performed? 2 PNo 1 ☐ Yes 1 □ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 1 No Certification: To 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Iniury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number D61731 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 N. CHARLES ST, PPE 209, BALTO, MD 21204

Registrar DHMH 17 Rev 1/2001

State

CARDEN

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day 2009 Year May 29, Elizabeth Fick 6:24 P Grace /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore 3528 Milford Mill Road Windsor Mill 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea. MAR 17, 1 Social Security Number Birthplace (State or Foreign Country) Funeral 1 M 2 X F Months Days Hours Min. Director 215-14-9135 1923 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or items 23a or 28a-f show Director MD Baltimore Windsor Mill 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3528 Milford Mill Road 21244 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examina once. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: þ 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Personnel Manager Retail 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) William Mitchell Grace Elizabeth Chaney Henry ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur L. Rhoads, Jr., Attorney 704 Frederick Road Catonsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 06/01/09 Baltimore, MD 22. Name and Address of Facility Cremation Society of MD, Inc. 21. Signature of Funeral Service Licensee George MacNabb Seor 299 Frederick Road Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause at each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 9 Unknown þ signed t nificant conditions g to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page perform certificate 2 No Hospital or Attending Physician: TP 44 hours after death. Funeral Director: After this certificate lely filled in by the funeral director, pag 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1☐ Yes 2 No Other: 4 \sum Nursing Home Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 Accident 2 🗆 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Funeral Directory To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) within to the F and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) June 1, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1314 Bedford Ave., Suite 101 Bruce H. Sindler, M.D. Pikesville, MD 21208 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** If Under 1 Year I If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 M 2 F Min. Months Director mu Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, The Medical Experience must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 41204 .S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 No Maryland 21215-0036 Specify: White 2 No 1 ☐ Yes Specify. ģ 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 0 ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mD 21204 Kiderwood Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 Removal from State timore. MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee ar YORK Rd Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** montle disease or condition resulting in death) year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, and in the cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy performed certificate 1 □ Yes 2 ****No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1∐Yes 2∐MÑo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 🗆 Yes 2 🗌 No 2 Accident 3 Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar illiam.

31. Date filed (Month, Day, Year)

onnell

32. Registrar's Signature

Examin

Funeral Director

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit. Medical Certification: To Be Completed by Physician/Medical Examir	Cause. Enter Underly Cause (Disease or inj that initiated events resulting in death) Lass IF FEMALE: 23b. Was decedent properties and in the past 12 mm 1
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State Registrar	31. Date filed (Month,
DHMH 17 Rev 1/2001	JI

	1 - State Registrar		(Certific	cate of l	Death			Reg. N	0.			
an	1. Decedent's Name (First, Middle NATHAN	e, Last)	FEINS	TEIN				2. Date of De	eath 3.	₫ ^y 2009	3. Time of Death 6:45 A M		
al er	4a. Facility Name (If not institution	-				SON				c. County of Death BALTI	MORE		
	5. Social Security Number 205-20-5549 Usual Residence of Decedent	6. Sex 1 X M 2 □ F	7. Age (In yrs. last birth		Inder 1 Year onths Days	If Under Hours	Min.	8. Date of Bir (Month, Di	/19	9. Birth Cou	place (State or Foreign ntry) PA		
	10a. State 10b. County		10c. City, Town	or Location	1					10d. Inside City Limits			
tor	MD N	/A	В	ALTIN	10RE						1 X Yes 2 □ No		
irec	10e. Street and Number			10	f. Zip Code				10g. C	10g. Citizen of What Country?			
al D	10 E. LEE STR	EET			21	202			USA				
ner	11. Marital Status	12. Was Deced	lent Ever in U.S.	13. Was E	Decedent of H	ispanic Or	rigin? (Spe	cify Yes or No					
Be Completed by Funeral Director	1 Never Married 2 Marr	ried 1 Yes 2	2 □ No		es 2XINo	Specify		Specify: WHITE					
q pe	3 Widowed 4 Divorced			Decedent's	Usual Occup	ation			16h	Kind of Business/Ir	d of Business/Industry		
plet	(Specify only highe	st grade completed)	(Give kind of	of work done of OT use retired	during mos	st of workir	ng		16b. Kind of Business/Industry			
mo	Elementary/Secondary (0-12)	College (1-4	+	ATI	TORNEY					LAW			
3e C	17. Father's Name (First, Middle,	Last)				18. Moth	er's Name	(First, Middle	e, Maide				
70	OSCAR	F	EINSTEIN					ONIA		MEIN			
	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10c. LEE STREET, BALTIMORE, MD 21202 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State)												
	20a. Method of Disposition Date Date 20c. Location - City of												
											i., INC.		
	23a. Part 1. Enter the disease, or	r complications that car	used the death. Do no					INLSVILLE	Approximate				
	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on ea					Interval Between Onset and Death						
_	Sequentially list conditions,	b	or as a consequence of								U		
amine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	6 c	or as a consequence o										
Completed by Physician/Medical Examiner	resulting in death) Last	d	er as a consequence of	r): 									
Med	IF FEMALE:												
ian/	23b. Was decedent pregnant in the past 12 months?	1 Live bi	ome of pregnancy irth 2 Fetal death		opic pregnanc	у			23d. Date of delivery Month Day Year				
/sic	1 □ Yes 2 □ No 9 □ Unknown	4 ∐ Pregna 9 ☐ Unkno	ant at time of death wn	5 🗌 Oth	er (specify) _								
Ph.	Part II. Other significant condition	ons contributing to dea	ath but not resulting in	the underly	/ing cause giv	en in Part	l.	23e. Did	o use contribute to	the cause of death?			
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lete								24a. Wa:	s an	24b. Were au	topsy findings available		
omp								auto perf 1 □Yes	opsy	death?	ompletion of cause of 2 □ No		
Be C	25. Was case referred to medica	ı				26. Plac	e of Death	1 ∐Yes (Check only		vo I Lites	2 🗀 NO		
	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ In	patient 2 ER/Out	patient 3	□ DOA Oth	er: 4 🗆 N	lursing Ho	me 5 🗆 Res	sidence	6 Other (Spec	in Hospice		
:uo	27. Manner of Death 1 ☑ Natural 5 ☑ Pendir	28a. Date o (Month		jury	28c. Injur Wor	k?		28d. Describe	how in	jury occurred			
cati	2 ☐ Accident investigned investigation invest	gation not be		N		Yes 2		2011	/=				
Sertifi	4 Homicide determ	ained Zoe. Flace c	of Injury - At home, fari g, etc. <i>(Specify)</i>	m, street, t	астогу, опісе			City or To	own, St	and Number or Ru ate)	rai Houte Number,		
Medical Certification: To		ng Physician: To the t Examiner: On the ba and manne	ata of accompanies at an am-	Man 1		-inion de	andle management	and at the time	doto	and place, and due	to the equec(c)		
Me	29b. Signature and title of certifie	my the	of death (Item 23a) (**C 670 /**) egistrar's Signature		29c. Licens	e number	05		29d.	Date signed (Month	2009		
	30. Name and address of person	who completed cause	of death (Item 23a) (** C 6701	Type, Print	Charl	e- S	t. A	alto.	6	nd Zi	207		
te ar	31. Date filed (Month, Day, Year)	2009 32 Re	egistrar's Signature	par	la d			-	_				
	JU11 V N												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. #35tePGTMBHXaG89De5692169R of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** INA 26 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 F 214460646 Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location per nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Derartment of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified as 1 Ves 2 No Director ltimore mD 10g. Citizen of What Country? 10e. Street and Number 21225 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No þ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Johnson ပ Merryman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela M. Tate 20a. Method of Disposition Daughter 630 Roundview Road Baltimore, MD 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City of Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State edar Hill Cemetary 5-30-09 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Pacility 21. Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** -oronaru disease or condition resulting in death) /Medical Due to (or as a consequence of): perte Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of): Examiner 2 Doiv Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 Yes 2 No 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and

burial-transit

and

certificate

P.O. I

Records,

Division of Vital

28a-f show

Baltimore, Maryland 21215-0036

State Registrar 700

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PHYSICIAN

D0059014

WASH INGTON

9-03749 ana Leigh Griffin	Please Type or Print in Black Indelible in	•	_						
ana Leigh Gillin	1- For State Certificate of		Reg. No. 2009 1754						
Physician			te of Death nth Day Year y 10, 2009 3. Time of Death 0432 hrs						
/ledical Examin		b. City, Town, or Location of Death	y 10, 2009 4c. County of Death						
	Northbound I-83 at Middletown Road	Parkton	Baltimore County						
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 219-25-8447 1 M 2 X F 22 Yrs.	If Under 1 Year If Under 24Hrs. 8. D Months Days Hours Min.	rate of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Maryland Country)						
	219-23-8447 1 M 2XF 22 Yrs. Usual Residence of Decedent		11y 4, 1986 ccanay,						
w any	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 Yes 2 No						
Maryland 28a-f show 3 at once.	Maryland Baltimore Parki 10e. Street and Number 501 Stablers Church Road	On 10f. Zip Code	10g. Citizen of What Country?						
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shumatic event, the Medical Examiner must be notified at once	501 Stablers Church Road	21120	USA						
th with tems 23 st be no	1 Never Married 2 Married Armed Forces? If Ye	Decedent of Hispanic Origin? (Specify s, specify Cuban, Mexican, Puerto Rican							
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5-0036 led within 72 Hygiene, other than "	Elementary/Secondary (0-12) 12 College (1-4 or 5+) Barte 17. Father's Name (First, Middle, Last)	ender	Restaurant						
15-00 illed wit Hygien d other		, , , , , , , , , , , , , , , , , , , ,	, Middle, Maiden Surname)						
21215-0036 Mental Hygiene. Merstal Hygiene. c event, the Medica	John Lawrence Griffin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Darleen Ki Address (Street and Number or Rural F	Route Number, City or Town, State, Zip Code)						
Baltimore, MD 2121 permit. Pages 1 and 2 should be fi Department of Health and Mental I Important: If item 27 is marked injury or other traumatic event,	Darleen L. Griffin, Mother 501 St		l Parkton, Maryland 21120						
Baltimore, MD oemit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other traumant.	1 Burial 2 X Cremation 3 Removal from State crematory or oth								
nit. Pagartment	21. Signature of Funeral Service Licensee Thomas Crocor 22. N	natory Inc. 05/30/							
Balti permit. Departm Imports injury o	Jamon Syram 299	PFEABrierie Royal	Maryland, Maryland 21228 iratory arrest, shock, or heart Approximate Interval						
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	Sequentially list conditions, if any, leading to immediate b								
	cause. Enter Underlying Cause (Disease or injury mai minared	· -							
			Trip.						
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Box 68760, death certificate be the attending physical for use as the burner of the bu	C Dast 12 months?	al death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year						
Box 6 e death cer the attendied for use	Yes 2 No 9 V Unknown g Unknown	er (Specify)							
		nderlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?						
ords, P.O. w requires that the sbeen signed by the should be detached.			1 Yes 2 No 3 Probably 4 ✔ Unknown 24a. Was an 24b. Were autopsy findings available						
Division of Vital Records, lat or Attending Physician: The law require safact death. at Director: After this certificate has been sited in by the funeral director, page 2 should be in the funeral director, page 2 should be in the funeral director.			autopsy performed? prior to completion of cause of death? ✓ Yes 2 No 1 ✓ Yes 2 No						
Vital Rec ysician: The his certificate director, page	25. Was case referred to medical	26.Place of Death (Check only o							
F Vit	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of Ir								
lon of tending Pheath. or: After the funeral		1 Yes 2 X No	Describe haw injury occurred vehicle 11ision						
ivision Atto	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stree	t factory office building etc. 28f.	Location (Street and Number or Rural Route Number, City or Town, State) $NB\ I-83\ @\ Middletow$						
Diviospital or hours after uneral Diviosity filled in	29a Certifier	Rd	, Parkton, MD						
Division To the Hospital or Attent Within 24 hours after death To the Funeral Director: Completely filled in by the	(Check only 1 Certifying Physician: To the best of my knowledge, death occurrence) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated. 29b. Signature and title of certifier	on, in my opinion, death occurred at the	time, date and place, and due to the cause(s)						
F % F 8	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)						
	30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.	May 10, 2009						
6 V	Jack Titus MD. Deputy Chief Medical Examiner 111 Pen	n Street, Baltimore, MD 21201							
Star Registra	at 31. Date filed (Monto, Day Year) 32. Registrar's Signature	Kel							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death y th Year 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 Physician a MSON 20 (9CE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospit Baltimore Randallstown North west Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 1□ M 2 F March 13,1908 Pennsylvania 101 206-20-9868 Director Usual Residence of Decedent 10d. Inside City Limits ould be filed within 72 hours after death with the Maryland Mental Hygiene.

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Department of Health and Mental Important: If item 27 is mo-Be Rebecca Marie Walton 2 Julius Bennett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2504 Queen Anne Road Baltimore, Maryland 21216 Ann C. Simmons, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, Maryland 05/29/09 Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Thomas 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Atheroschotic Immediate Cause (Final nonona **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, physician the attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has le 2 autopsy performed page 21 No 1 Yes certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 □ DOA 1 🔲 Inpatient After this of မ 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural within 24 hours after deaun.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Pay, Year) 29c. License number 29b. Signature and title of certifi 200 30. Name and address of Parson who completed cause of death (Item 23a) (Type, Print) DVVT Road 32. Registrar's Signature 31. Date filed (Month Year) State

DHMH 17 Rev 1/2001

Registrar

JUN 0

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State	of Maryla	nd / Depa	artment rtificate			and M	-	giene Reg. No	2000	17551
	Physici		1. Decedent's Name (First, Middle Elois Good	, Last)							2. Date of De Month May	ath 27 ^{Da}	y 2009 ear	3. Time of Death 6:10p M
	/Medic		4a. Facility Name (If not institution	, give street and nu	ımber)		4b. City, T	own, or	Location	of Death			. County of Deat	
-	LAGIIII	101	Tate House		,		Lint						Anne Ar	undel
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	s. last birthday)	If Under	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th av Year)	9. Birt	hplace (State or Foreign untry)
-	Director		577-58-6422	1□M 2፟M F	6	4 Yrs.	WOTHINS	Days	Hours	(VIII I.	10/28/	44	Was	hington,DC
	and		Usual Residence of Decedent 10a. State 10b. County		100.0	City, Town or Lo	cation							10d. Inside City Limits
	Maryli f sho	ō		e Georges		t. Wash		n						1 XYes 2 ☐ No
	the M	Director	10e. Street and Number				10f. Zip					10a. Ci	tizen of What Co	untry?
	3a or	<u>[</u>	8815 Oak Lane					744				US		
	death ms 2	Funeral	11. Marital Status	12. Was Dec	edent Ever in I	U.S. 13.			spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)		14. Race - Ame	
9	after or ite		1 ☐ Never Married 2 ☐ Marri	ed 1 ☐ Yes If Yes, G	21 No		ir Yes, speci 1 □ Yes 2		n, Mexicar Specify:		Hican, etc.)		Black, White Specify: B1	
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d 2	filed Hygi other		17. Father's Name (First, Middle, I	Last)		Manag	er		18. Mothe	er's Name	(First, Middle		ivate	
<u>a</u> n	id be ental ked c	To Be	Samuel Pinkard	,							n Rose			
ary	shou and M s mar umat	-	19a. Informant's Name/Relationsh	nip (Type. Print)		19b. Mailir	ng Address	Street a					or Town, State, 2	Zip Code)
Ž	alth a		Vinson L. Good	/Husband		8815	Oak La	ane,	Ft.	Wash	ington	,MD	20744	
J.	es 1 a of He item		20a. Method of Disposition		20b.	Place of Dispo	sition (Name	e of ner place	9)	D	ate	20c. L	ocation - City or	Town, State
Ē	Page ment ant: if		1 ☐ Burial 2 ★ Cremation 4 ☐ Donation 5 ☐ Other (S _i		State	.Lincol				5/2/0	19	Bre	ntwood,	MD
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Modical Examination to Indiffer a none.		21. Signature of Funeral Service	icensee		22	2. Name and	Addres	s of Facilit	y Ft.	Linco	1n F	uneral	Home
	0. L = 6 0	_	Jun 7	un		3	401 B	lade	nsbur	co Rd	. Bren	twoo	d,MD 20	722
þ	Physician /Medical Examiner		2 Part1 Enter the dise or shoc or heart failure. List immediate Cause (Final disease or condition resulting in death)	a	each line.	so phi	r (yn)	y & e			interpretation of			Approximate Interval Between Onset and Death
3,09Z8	be executed sician and burial-transit	ıl Examiner	Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a conse				·					
O. Box 687	or Attending Physician: The law requires that the death certificate be executed bitred death. Diffector: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the bunal-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ □ No 9 □ □ Unknown	1 Live	tcome of pregi birth 2 Pei nant at time of nown	tal death 3	☐ Ectopic pro ☐ Other (spe			1.55 W ==	197(04),55		23d. Date of del Month	ivery Day Year
σ.	that the led by detax		Part II. Other significant condition	ns contributing to d	eath but not re	sulting in the u	nderlying ca	use give	n in Part I.		23e. Did t	obacco	use contribute to	the cause of death?
rds	uires n sigr lid be	d by	_								1 🗆	Yes 2	□ No 3□ Pr	obably 4 D Unknown
ō	w requir s been s should	Completed									24a. Was	an	24b Were au	itopsy findings available
æ	: The law cate has page 2:	шc									auto	psy rmed?	prior to death?	completion of cause of
tal	iclan: The certificate ector, pag	Be C	25. Was case referred to medical						26 Place	of Death	1 ☐ Yes	2 DX(No	1 ☐ Yes	Hatrice
<u> </u>	Physici this cer al direct		examiner? 1 ☐ Yes 2 🔼 No	Hospital:	Inpatient 2 [☐ ER/Outpatier	nt 3 □ DO/	Othe					6 SOther (Spe	11111
0	Jing Ph	<u>-</u>	27. Manner of Death	28a. Date	of Injury oth, Day, Year)	28b. Time o	f 28	c. Injury Work			28d. Describe			71045
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after dead or To the Funeral Director; After this certific completely filled in by the funeral director.	Certification: To	1 Natural 5 Pending investig 3 Suicide 6 Could n determi	ation		home, farm, str	М	1 🗆 Y	′es 2□		28f. Location (City or To			ıral Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical ((Check only 2 Medical I	g Physician: To the Examiner: On the b and man	e best of my kr basis of examin ner stated.	nowledge, deat nation and/or in	vestigation,	in my op	oinion, dea	nd place, ath occurr	and due to the ed at the time,	date an	d place, and due	to the cause(s)
•	wit con	2	29b. Signature and title of certifier	2010	R	1	2	License	31	(5	1	29d. Da	ate signed (Monti	0 100 9
	Sta	te	30. Name and address of person v	Klin	se of death (Ite	an 23a) (Type,	Print)	250	ital	10	11×°C, (5/6	Sura:	7, Ad. 21061

DHMH 17 Rev 1/2001

		,	For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of F ertificate of		/lental Hy	giene, Reg. No.	711114	17552			
	Physici /Medi		1. Decedent's Name (First, Middle, La DAVID	H		GREENBER	G	2. Date of De	ath 30 ay	2009	3. Time of Death 10:40 A M			
	Exami		4a. Facility Name (If not institution, gi				r Location of Death		4c. C	4c. County of Death BALTIMORE				
ŕ	Funeral Director		3401 MIDFIELD 5. Social Security Number 220–18–8039		e (In yrs. last birthday) 86 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Bir Month, Da 09/06/						
	ъ		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	paction					10d. Inside City Limits			
	f show	ō		IMORE	TOG. City, Town or Lo	PIKESVIL	l E				1 ☐ Yes 2 🎇 No			
	r 28a-	Director	10e. Street and Number	THORL		10f. Zip Code	<u> </u>		10g. Citiz	en of What Cou	untry?			
	th with	al D	3401 MIDFIELD	ROAD		212	08			USA				
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modical Evarring it ust be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🂢 Widowed 4 ☐ Divorced	12. Was Decedent B Armed Forces? 1 MYes 2 N If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🎇 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		4. Race - Amer Black, White Specify: WH				
5-0	72 ho 'natur	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	i (Give	edent's Usual Occup	during most of work	ing	16b. Kin	16b. Kind of Business/Industry				
121	within lene. than "	dmo	Elementary/Secondary (0-12)	College (1-4or 5-	+)	DO NOT use retired OWNER	d) -		COMMI	ERCIAL	RFALTY			
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ılan	should be find Mental I	To B	NATHAN	GREE	ENBERG		IDA			HOCHMAN				
Maryland	2 short and land lis ma is ma		19a. Informant's Name/Relationship		ŀ	ing Address (Street					ip Code)			
	1 and 2 Health em 27 i		MARCIE LOWE / Da	AUGHTER	20b. Place of Dispe	QUILL LA		ND, PA		075 cation - City or T	Town State			
Baltimore,	t, Partmentant:		1 N Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	fy)	O'HEBY 'S' MEMORI	MATOM ^{ther place} AL PARK	06/01	/2009	RE	ISTERST	OWN, MD			
Ba	Department on the partment of the partment of	(21. Signature of Funeral Service Lice	Vome		2. Name and Addre 8900 REI				& BROS ESVILLE	., INC.			
	Physician /Medical		23. P rt1. Enter the disea or con shock, or heart failure. I Immediate Cause (Final disease or condition resulting in death)	a.	the death. Do not ente.		ng, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death			
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_	entific ding p	Med	IF FEMALE:	202 16	100 000									
.O. Box	at the death certific by the attending p tached for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of the street of the st	2 Fetal death 3	☐ Ectopic pregnand ☐ Other <i>(sp</i> ec <i>ify)</i> _	2	23d. Date of delivery Month Day Year						
rds, P.	quires that en signed b uld be deta	ğ	Part II. Other significant conditions	contributing to death bu	ut not resulting in the u	underlying cause giv	en in Part I.				the cause of death?			
of Vital Records,		Completed							psy ormed?	prior to o	topsy findings available completion of cause of			
/ita	Physiclan: Th r this certificate ral director, pag	Be (25. Was case referred to medical examiner?	ļ		l au	26. Place of Deat	h (Check only	one)					
of	Phys this al dii	<u>1</u>	1 ☐ Yes 2 M No 27. Manner of Death	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatie		4 Li Nursing no				cify)			
Division	tending eath. or: After the fune	Certification:	1 Natural 5 Pending 2 Accident investigatic 3 Suicide 6 Could not be determined	(Month, Day on 28e. Place of Inju	y, Year) Injury	M 1□	yat k? Yes 2 □No	28d. Describe	(Street and		ral Route Number,			
Ö	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by '		29a. Certifier 1 € Certifying P	building, etc	of my knowledge, dea			, and due to the						
	To the Ho within 24 To the Fu	Medical	one)	miner: On the basis of and manner sta				rred at the time						
	N With	Δ	29b. Signature and title of certifier	: Bey, MD		29c. Licens			5/3	e signed (Month	n, Day, Year)			
	0 V		30. Name and address of person who Ruchar	d A. Bers, HO	; Suite 450; 107	155 Falls Road	; Lutherville, he	21073						
	Sta Registr		31. Date filed (Month, Day, Year) JUN 0 2 20	32 Registra	ar's Signature	aled								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 01:10 AM 200 WODZAJD MAY /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE WASHINGTON MEDICAL CENTER BURNIE ARUNDEL GLEN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 03 Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Guyana South America Social Security Number **Funeral** 1☑M 2□F Months Days Hours Year) 109-56-4272 48 1961 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 ☑ No Director Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1010 Fitzallen Road 21060 IISA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled 12 Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Courtney Glasgow Jovce Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tonce. Cynthia M. Glasgow (spouse) 1010 fitzallen Road, Glen Burnie, MD 21060 Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State June 06 Woodlawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 2009 21. Signature a Funeral Service 2 cersee 22. Name and Address of Facility Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1 Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MYOCARDIAL INFARCTION 23TUUIM OP /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ ASTHMA, SARCOIDOSIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 🔼 No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 □ No 1 Nation 2 I ER/Outpatient 3 I DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

or Attending Physician: The law requires that the death certificate be executed burial-tran and the attending physician Division of Vital Records, P.O. Box 68760. the use as signed by the a has this certificate After after death Director:

show

is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examinar must be a ciffed at

Baltimore, Maryland 21215-0036

GLASGOW

Pages 1 and 2 should be filed withir nent of Health and Mental Hygiene. ant: If Item 27 is marked other than

the

filled in by

29a. Certifier

(Check only one)

29b. Signature and title of certifier

within 24 hours a Medical the

State Registrar

Chillerens José Crieng per

JUN 0 2 2009

29d. Date signed (Month, Day, Year) 29c. License number

MAY 29, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CUILLERMO JOSE GIANGRECO 301 HOSPITAL DRIVE, CLEN BURNIE, MD 20161-5803

31. Date filed (Month, Day, Year)

32. Registrar's Signature Jack

1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

11553000

09-04188 Debra Gaines		Please Type or Print in Blac State of Maryland / D	k Indelible Ir	nk. Ensur	e All Copi	es Are L	egible.			
		1-For State Registrar	Certificate of		u Mentai F	iygierie	2			
Physici Medical Exami		1. Decedent's Name (First, Middle,Last) Debra Gaines Debra	Diane Jone			2. Date of D Month May 26,	Day Yea	Time of Death 5 5		
		4a. Facility Name (if not institution, give street and number) 2431 Arunah Avenue	4	b. City, Town, or Baltimore	Location of Deat	n	4c. County of	of Death \		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In 1 M 2 X F	yrs. last birthday) 53 Yrs.	If Under 1 Year Months Day		_	1-1956	9. Birthplace (State or Foreign Country)		
v any		Usual Residence of Decedent 10a. State 10b. County 10c.	c. City, Town or Locati	on				10d. Inside City Limits		
Maryland 28a-f show	Director	10e. Street and Number	Kaltimo	10f. Zip Code			10g. Citizen of Wh	1 Yes 2 No		
with the N is 23a or	ral Dir	2431 Arunah Avenue 11. Marital Status 12. Was Decedent Eve	er in U.S. 13. Was	2/2/	16 spanic Origin? (S	necify Yes or I	USA	- American Indian, Black,		
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene and the Hosp of Health and Mental Hygiene winatural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 3 Widowed 4 Divorced If Yes, 6ive Year	No If Ye	es, specify Cubar	specify:	Rican, etc.)	White Specify:			
936 thin 72 hour ne. than "natu	ompleted	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent	s Usual Occupation of working life	tion (Give kind of . DO NOT use ret	work done ired)	16b. Kind of B.	tiness/Industry		
imore, MD 21215-0036 Pages I and 2 should be filed within 7 ment of Health and Mental Hygiene Inter. Intern 27 is marked other than or other traumatic event, the Medical	Be C	17. Father's Name (First, Middle, bast) Herman Gaines			Kosa	lie F	e, Maiden Surname)			
MD 21 rid 2 should 1 filth and Mer m 27 is mar	L L	Mother Holland Mother	19b. Mailing 222	Address (Stree	et and Number or	Rural Route N	umber, City or Town	n, State, Zip Code) Mary Land 21216		
Baltimore, Demit Pages I an Department of Hee Important: If iter		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	20b. Place of Disposi crematory or oth		metery,	Date 2 - 10	20c. Location -	City or Town, State		
Baltimo permit Page Department Important: injury or otd		4 Donation 5 Other Specify: 21. Signature of Funeral Service Ucensee	22. N	ame and Address	of Facility V	yohn (Jeene Jeene	Furieral Serv		
Physician	foilure List only one course or each time									
/Medical Examiner	Medical failure. List only one cause on each line.									
,	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated C.	ence of):							
mand scuted and transit	al Examine	events resulting in death) Last Due to (or as a conseque								
	edic	X UNPENDED X AMENDED 33 a, 2 pe		f0/13/0	92 6/4/0 9 TT	9 TT	22d Date of	dolivon		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be extwittin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.	hysician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 V Unknown 1 Unknown	2 Fet	al death 3 [er (Specify)	Ectopic pregna	ancy	23d. Date of Month	Day Year		
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Division of To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Certification:	Natural 5 Pending (Month, Day,Year) 2 X Accident Investigation 28e, Place of Injury.	9 Fd 11:0	ou am	res 2 XNo	subjec		or Divid Douts Number City		
Div Hospital or 24 hours aft Funeral Di	Certif	4 Homicide determined (Specify) foun	d at home			Balti	more, MD	er or Rural Route Number, City Arunah Ave		
To the II within 24 To the F complete	Medical	(Check only one) 2 Medical Examiner: On the basis of examinal and manner stated.	owledge, death occurre tion and/or investigation	on, in my opinion,	, death occurred a	due to the ca	e and place, and do	ue to the cause(s)		
	2	29b. Signature and title of certifier Potter Que, Poller	- 10	29c. License O.C.N			29d. Date signe May 27, 20	ed (Month, Day, Year) 09		
\bigcirc \emptyset		 Name and address of person who completed cause of death Patricia Aronica-Pollak MD. Assistant Medi 	cal Examiner	111 Penn Sti	reet, Baltimor	e, MD 212	01			
Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Si	gnature	<u> </u>						

P.O. Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1, Decedent's Name (First, Middle, Last) **Physician** 12:00 PM May 27, 2009 Ellen Theresa Granger /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Longview Nursing Home Carrol1 Manchester Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 👿 F 87 214-18-1831 Marvland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 21 No Funeral Director MD Carroll Westminster 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with to nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or? USA "natural", or items 23a 1619 Terrace Drive 21157 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: White Completed by 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator Glass Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျှ Charles Bloom Lillain McAuliffe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1619 Terrace Drive Westminster, MD 21157 Mrs. Barbara Bruce, Daugher 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot May 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Glen Burnie, MD Atlantic Crematory 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Singleton Funeral and Cremation Services 1 2nd Ave SW M01220 Glen Burnie, MD 21061 23a. Prrt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Dement **Physician** Advanced /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner pital or Attending Physician: The law requires that the death certificate be executed ours after death.

Leral Director: After this certificate has been signed by the attending physician and illied in by the funeral director, page 2 should be detached for use as the burital-transit Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 XNo 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 🕍 No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27, Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours af To the Funeral Di 😿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D 51705 05-27-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8 Hampstoud MD 21074 M. PANSUR(YA 2111 Harwet 31. Date filed (Month, Day, Year) 32. Jegistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. / 2. Date of Death 1. Decedent's Name (First, Middle, Last) 0009 IICICO Ci Tona 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) N/A **Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign
Country) Date of Birth (Month, Day, Year)
2-1-1944 If Under 1 Year 5. Social Security Number Age (In yrs. last birthday, If Under 24 Hrs Days Min 1 XM 2 □ F MARYLAND 214-38-9771 65 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 X Yes 2 ☐ No MD. N/A BALTIMORE 10g. Citizen of What Country? 10f. Zin-Code 10e. Street and Number 2729 E. BIDDLE ST. 21213 **USA** 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 XYes 2 [If Yes, Give Year or Dates 1 Never Married 2 XMarried 2 🗌 No 1 ☐ Yes 2 XNo Specify: Specify: BLACK 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) -12--0-MACHINIST LABOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) RICHARD GILLIAM ESTELLE STAINBACK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MARY F. GILLIAM(WIFE) 660 KINGSTON CT. BALTIMORE, MARYLAND 21220 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1X Burial 2 Crema 3 Removal from State CARRISON FOREST VETERANS 6-3-2009 OWINGS MILLS, MARYLAND 5 Cother (Specify) 4 Donation HIBNER2. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. censer JONATHAN 21. Signature of Funeral Service D. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part a Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh/o, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Sis OV ue to (o as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) 2 No 23e. Did tobacco use contribute to the cause of death? 2 No 3 □ Probably 4 □ Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 Yes 26. Place of Death Check only one

Physician /Medical Examin

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours afternent of Health and Mental Hygiene.

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traumatic event, the Medical

Department of Health a Important; If item 27 is any injury or other trainonce.

Baltimore, Maryland 21215-0036

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Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

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disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease 1) that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 5 Pending investigation Injury 1 Natural 1 🗌 Yes 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Could not be 3 Suicide determined City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

+1 Elisabeth

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

State Registrar 31. Date filed (Month, Day, Year) JUN 0 2 2009

Registrar's Signature

RZS-000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 10:30 pm Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 29, Margaret Renfrew Gray May 2009 6:30 P /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore のなるの Baltimore Oak Crest Village If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Funeral Hours Months 1 □ M 2 🛛 F 075-16-5209 86 Director 1923 New York Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a. State 10b. County 1 ☐ Yes 2 ☑ No ns 23a or 28a-f sl Director Maryland Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 8832 Walther Blvd. 21234 USA Funeral Items (14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married ō 1 ☐ Yes 2 ☑ No Specify Specify: the Medical Exp. ģ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Insurance Secretary Department of Health and Mental Hygie Important: If item 27 Is marked other i any Injury or other traumatic event, In <u>once.</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f ment of Health and Mental ပ John Simpson Gray Mary Milton Robertson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John S. Gray / Nephew 3220 Darden Drive, Woodbridge, VA 22192 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6-3-09 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A. athlee 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) atherosclerotic Cardiovaxular Disease **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Litis to (or as a consequence of) Examiner the Hospital or Attending Physician; The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Februlation, Perceptural Vascular 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: 1 ☐ Yes Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 24 hours after death.
Funeral Director: After the etely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 5/29/2009 ted cause of death (Item 23a) (Type, Print) 8800 Walther Blud, Parkville, NO 21234 6 Harroon 31. Date filed (Month, Day, Year)

State Registrar

Registrar

P.O.

Amend 20b, perFH 8892 6/4/09 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Hamilton 25 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Winding Brook Baltimore Baltimore 9. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. Date of Birth (Moeth, Day, 7. Age (In yrs. last birthday) **Funeral** Months M 2□ F Days 162.22.074 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore NID Baltimore Funeral Director 1 ☐ Yes 2 No If item 27 is marked other than "natural", or items 23a or 28a-f or other traumatic event, its Medical Evantion rough to recitie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: White 3 Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore County College (1-4or 5+) Elementary/Secondary (0-12) Counselor Public Schools 12th arade 17. Father's Name First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21244 19a. Informant's Name/Relationship (Type. Print) Baltimore, MD BrookWay - Won 1730 Winding 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date (194 permit. Pages 'Department of H Important: If ite any Injury or of 1 Burial 2 Cremation 3 Removal from State Baltimore, MD 06/04/2009 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Chematon 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaugem C. Greene Fungentsus Road (Randallstown MD 21133 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) LUNG CANCER NON SMALL CELL Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any country list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of sician and burial-trans Due to (or as a consequence of) P.O. Box 68760, signed by the attending physician Physician/Medical use as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 **N**0 1 □Yes 2 No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MD D 16354 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WCOLE 900 AVE BALTIMORE MD CATON 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 _ State	partment of Health and Merertificate of Death		ne No.2009 7560
			Registrar 1. Decedent's Name (First, Middle, Last)		Date of Death	3. Time of Death
	Physicia /Medic		Jenora D. Hill	l M		2009 Year 8:25 A. M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
1			Holy Cross Hospital	Silver Spring (i) If Under 1 Year If Under 24 Hrs. 8,		Montgomery 9. Birthplace (State or Foreign
ь.	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 6. Yrs. 64	Months Days Hours Min.	Date of Birth (Month, Day, Ye eb . 25,	Par) Country) DC
			Usual Residence of Decedent		,	
ıvlan	show	_	10a. State 10b. County 10c. City, Town or I	.ocation		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
he Ma	28a-f s	Director	MD Prince George's Greenbel		10-	Citizen of What Country?
with t	a or the n		10e. Street and Number 9340 Edmondston Rd. Apt. #203	10f. Zip Code 20770		U.S.A.
eath	ns 23 must	Funeral		. Was Decedent of Hispanic Origin? (Specifi If Yes, specify Cuban, Mexican, Puerto Rici		14. Race - American Indian,
after o	or iter niner	F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	If Yes, specify Cuban, Mexican, Puerto Rici 1 ☐ Yes 2 ☒ No Specify:	an, etc.)	Black, White, etc. Specify: Black
d 21215-0036 filed within 72 hours after death with the Maryland	Iral",	d by	3 ☐ Widowed 4 🏿 Divorced If Yes, Give Year or Dates:			
15-1	"natu	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation be kind of work done during most of working DO NOT use retired)	16t	b. Kind of Business/Industry
12 with	than	E G	Elementary/Secondary (0-12) College (1-4or 5+)	ekeeping	์ บ	.S.Gov't
کا کا االوط	other other vent,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (F	irst, Middle, Mai	den Surname)
ylar ylar	Menta arked atic e	2	George W. Dixon	Viola Mae	e Wilson	
Aar 2 sho	n and is m raum			ling Address (Street and Number or Rural R		
6, 6	Healt em 27 ther 1			Edmondston Rd., Apt		c. Location - City or Town, State
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours aft	Department of Health and Mental Hygiene. Important: or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Modical Evaniner must be notified at once.		1 M Burial 2 Li Cremation 3 Li Hemoval from State 1	position (Name of ematory or other place) coln Cemetry June 1	2000 Br	contrand MD
	oortan Jujur	1	21. Signature of Funeral Service Licensee	Funeral Home		
ä	ang July		I cluane a. Coffeler :	3401 Bladensburg Rd.	, Brenty	wood, MD 20770
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or re	espiratory arrest	Approximate Interval Between Onset and Death
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	Medical xaminer		resulting in death) Due to (or as a consequence of):			
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin			
P E	ansit	Examiner	causé. Enter Underl in Cause (Disease or injury that initiated events c.			
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Division of Vital Records, P.O. Box 68760, L. for the Hospital or Attending Physician: The law requires that the death certificate be executed	g physician and s the burial-transit	dical	d			
×6	attending p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
Box death cer	atter d for u	iciar	1 ☐ Live birth 2 ☐ Fetal death 3 in the past 12 months? 4 ☐ Pregnant at time of death 5	Ectopic pregnancy Other (specify)		Month Day Year
P.O.	detached	Physician/Me	9 Unknown			
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Vit Sicia	s certi	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient	26. Place of Death (C		ce 6 ☐Other (Specify)
of Physical	h. After this funeral dir	n: T	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at 28c	d. Describe how	
Sior	eath. or: Af the fur	atic	2 Accident investigation	M 1 □Yes 2 □No	- 23	and the factor of the factor o
Division of Vital Records, I or Attending Physician: The law requires the	after deat Director: I in by the	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office 28f.	f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
pital	within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1⊠ Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place, an	d due to the cau	se(s) and manner as stated.
e Hos	within 24 hours To the Funeral completely filled	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.			
To th	within 2 To the comple	Me	29b. Signature and tille of certifier	29c. License number	29d	. Date signed (Month, Day, Year)
	•		Junio Mo	D-32332	M	ay 27, 2009
	3		30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print) ., #220 Silver Spri	ng MD	20902
	Sta	te		, 17220 SILVEL SPIL	ng, rm	20702
	Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature 3. Agarda			

09-04275 Jan

or Print in Black Indelible Ink Ensure All Conies Are Legible.

04275		Please Type	e of Maryland	/ Dena	rtment o	nk. Ens f Health	and M	/lental	l Hvai	ene		2000	1756
net Carol Hitt	1	- For State	e or ivial yland		tificate o		and iv	VIOITICA		Reg		2009	1756
Physicia		Registrar 1. Decedent's Name (First, Middle,I	ast)							ate of Death	Day Yea		ime of Death
edical Examin		Janet C.	Hitt						M	ay 29, 200)9)633 hrs
		4a. Facility Name (if not institution,	give street and number)		4b. City, Tow Middle F		ation of D	Death		4c. County	of Death re County	
	4	120 Conestoga Road		o (louro la	ast birthday)	If Under 1		If Under 2	94Hrs. 8.	Date of Birth	(MM/DD/YYY)		
Funeral Director	1			ge (III yrs. 1a 4		Months		Hours	1.6-		5,1962	Foreign	
Director	ļ	216-78-6163 1 Usual Residence of Decedent	M 2X F		6 Yrs	s				осре-	71302	-	
any	ŀ	10a. State 10b. County		10c. City,	Town or Loca								d. Inside City Limits
*	_	MD Balti	more		Midd	le Ri	ver						Yes 2 X No
faryla 28a-f	Director	10e. Street and Number	_			10f. Zip Co	ode 2122	20		100	. Citizen of W	hat Country?	?
vith the Maryland s 23a or 28a-f show a e notified at once.		120 Conestog											Indian Disele
h with	uneral	11. Marital Status 1 Never Married 2 X Marr	12. Was Deceden		S. 13. W	as Decedent Yes, specify (of Hispan Cuban, M	nic Origin Iexican, P	? (Specif Puerto Rica	y Yes or No- an, etc.)		e - American te, etc.	Indian, Black,
or deal	Fur		1 Yes 2 ced If Yes, Give Yeer	X No		Yes 2X	No s	pecify:			Specify:	Whi	te
ırs aftı tural" ımine	희	15. Decedent's Education (Specif	or Dates:	mpleted)	16a. Decede	ent's Usual Oc	cupation	(Give kir	nd of work		16b. Kind of B	usiness/Indu	stry
72 hor	ompleted	Elementary/Secondary (0-12)	College (1-4 or	5+)		most of workir	ig lite. DC	ONOTUS	se retirea)		Crab	Ouar	tors
vithin ene.	힅	12th			Wait	ress	Local		No (Fi	- A Missello M			cers
Hygi d other	O	17. Father's Name (First, Middle, L					18.1				aiden Surnam	e)	İ
212 Id be Mental marke event	o Be	John C. McG			19b. Maili	ng Address	(Street ar	nd Numb	tri(er or Rura	Route Numl	per, City or To	wn, State, Zi	p Code)
e, MD 21215-0036 Hand 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f short ranumatic event, the Medical Examiner must be notified at once	-1	Larry B. Hit		ıd					Road	d Bal	timore		
e, Nand I and Health item	-	20a. Method of Disposition			Place of Dispo crematory or o	other place)		I .		ate	20c. Location	•	
nor Pages ent of nt: If		1 X X Burial 2 Cremation 4 Donation 5 Other Spe		OA	k Law	n Cem	etei	ry	6/2	/09	Balti	imore	MD
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		21. Signature of Funeral Service L	icensee		22.						Ave.		
		23a. Part I. Enter the disease, or o	- Our	7	De set enter	Conn	elly	y Fu	inera	al HOI	ne of	Esse:	x 21221 Approximate Interval
Physician i l		failure. List only one cause of	n each line.							op.i.d.ory	,		Between Onset and Death
caminer		Immediate Cause (Final disease or condition resulting in death)	a. Hyperten Due to (or as a con			vascul	ar d	1sea	se				
		Sequentially list conditions,	b										
	ner	if any, leading to immediate	Due to (or as a con	sequence o	of):								
	cam	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a con	sequence o	of):								
executed an and al - transit	ical Examiner		d	30 27	,perME	6897	672	2709	<u> </u>	1 20 1	noted		
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tox 68760, eath certificate be a strending physicia for use as the burit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outo	ome of preg		Fetal death	3	Ectopic	pregnanc	y	Month	of delivery Day	y Year
x 68 h certi tendin use a	icia	past 12 months?	4 Pregnant	at time of d	eath 5	Other (Speci	(y)				1		
Box ne death of the atter	hys	1 Yes 2 No 9 V Unki	9 Olikilowii		ding in th	e underlying (nuea niv	on in Par	+1	23e. Did to	bacco use co	ntribute to th	e cause of death?
, P.O. res that the signed by be detach	by P	Part II. Other significant condition	ons contributing to de	ath but not	resulting to the	e underlying t	ause giv	remmi a					bly 4 🗸 Unknown
rds, I requires been sig	ted									24a. Was			psy findings available
COFC law re has be	Completed										rmed?	death?	mpletion of cause of 2 No
tal Rec cian: The l certificate ector, page	Co	OF West and the medical				2	S Place o	of Death (Check on	1 Yes	2No	1 Yes	2
Vital ysician: his certif director,	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpa	itient 2	ER/Outpatie		10	other 4		Home 5	Residence (6 🗸 Other:	Scene
of Viring Physical After this funeral dir	1: To	1 Yes 2 No 27. Manner of Death	28a. Date of I (Month, Da		28b. Time o	of Injury 2	3c. Injury	at Work	? 2	8d. Describe	how injury occ	curred	
On tendin sath. or: A	tior	1 X Natural 5 Pend 2 Accident Inves		y, rour,			1Ye	es 2					
Division of Vital Records, tal or Attending Physician: The law requir as pare deal. In Director: After this certificate has been sted in by the funeral director, page 2 should I	ertification:	3 Suicide 6 Could	not be 28e. Place of	Injury - At	home, farm, s	treet, factory,	office bui	ilding, etc	c. 2	8f. Location (or Town, \$		mber or Rura	al Route Number, City
Spital nours a	Cerl	4 Homicide	mined (Specify)						4	- 4- 45	e (a) and man	nor as state	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri		29a. Certifier 1 Certifying Prone Medical Example 29a. Certifying Prone 2 Medical Example 20a. Certifying Prone 20a. Certifying Pron	nysician: To the best of miner: On the basis of e	my knowle xamination	dge, death oc and/or investi	curred at the gation, in my	time, date opinion, e	e and pla death oc	ice, and d curred at t	ue to the cau: the time, date	se(s) and man and place, ar	nd due to the	cause(s)
Tot with Tot	Medical	29b. Signature and title of certifie	and manner state	ed			License						th, Day, Year)
		De not A	willall ve	111			O.C.N	1.E.			May 29,	2009	
		30. Name and address of person	who completed cause of	of death (Ite	m 23a)						<u> </u>		
DV		Pamela E. Southall, M				111 Penn	Street,	Baltim	nore, Mi	D 21201			
	tate	31. Date filed (Month, Day, Year)		trar's Signa		barrel							
Regis	tra	IUN 0 2	6000 Ken	and .	p. 9	artes							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** 3000 2009 Marz Hovelin /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Birthplace (State or Foreign Country) Seroson Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday Social Security Number **Funeral** Months Davs Hours 1 M 2 Z F Yrs PA 10-31-1926 82 Director 206-18-8296 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c City Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Madical Ever. In critist by Defined a once. 10b. County 10a. State 1 ☐ Yes 2 No Director Baltimore Randallstown MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 8620 Dovedale Road 21133 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify: White þ 3 Widowed 4 Divorced Completed 16h Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate 12 Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Abraham Elias Namie ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8620 Dovedale Road, Randallstown, MD 21133 Alan D. Havelin-Husband 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ACremation 3 ☐ Removal from State Bayview Crematory 6-1-09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bradley-Ashton Funeral Home 21. Signature of Juneral Willow Spring Road 21222 2134 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CASTRUCTUR Chrom- e /Medical Due to (or as a consequence of): **Examiner** neu man-Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) s been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 st 2 No 2 No 1 ☐ Yes 1 Yes 26. Place of Death (Check only one) director, 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) // CS) C2 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

State Registrar

丁、 31. Date filed (Month, Day, Year)

JUN 0 a 2009

29b. Signature and title of certifier

5310 32. Registrar's Signature

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

02908

C00.- 5

29d. Date signed (Month, Day, Year)

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat Month MAY Day 1. Year **Physician** 01:34FM Odo Ruth Higdon /Medical 4c. County of Death timore 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours 1 □ M 2CXF Min. 214-20-6788 83 Director 15, 1926 Maryland Jan. Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City. Town or Location nem 27 is marked other than "natural", or items 23a or 28a-f shoi other traumatic event, it w Medical Examinar must be notified at 1 ☐ Yes 💢 No Director Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 42 Tudor Court 21093 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or Ite 1 Never Married 2X Married altimore, Maryland 21215-0036 1 ☐Yes 2X No Yes. Give Specify: White 2 3 Widowed 4 Divorced Year or Dates Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Noxell Corporation Secretary 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas George Gosnell Lillian May Carl 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) R. Bruce Higdon Husband 42 Tudor Ct. Timonium, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. ₩Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Pleasant Cemetery 6/4/2009 4 ☐ Donation 5 ☐ Other (Specify) Gamber, Maryland 21. Signa urg of uneral Service Lice 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland 23a. Part 1. Spher the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ANOXIC ENCEPHALOPATHY **Physician** /Medical Due to (or as a consequence of): CARDIAC ARREST Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence oi). be executed ISCHEMIC CARDIOMYOPATHY sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 Other (specify) P.O. 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed DIABETES MELLITUS 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No certificate 2 🗆 No Division of Vital 1 Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To After this funeral 27. Manner of Death 28a. Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar 29b. Signature and title of certifier

7601 OSLER DRIVE TOWSON, FRANCIS KHOO. M. D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 0 2 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

D30263

29d. Date signed (Month, Day, Year)

MARYLAND

-31-09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland, Department of Aeath and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 26 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE AGHES HOSPITAL If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 1) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Year) Months -26-631 Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Modical Examiner must be notified at Haltimore 1XYes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Inficello Road Funeral 14. Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) reeman Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Ştate, Zip Code) Finksburg 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City & Jown, State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee . Greene Funeral St 212221 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final METASTATIC OVARIAN CANCER 34EARS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MONTHS SEVERE ANEMIA Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine 1 WEGK burial-transi PNEUMONIA attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 I WEEK Physician/Medical URINARY TRACT INTECTION IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Year 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 1 ☐ Yes 2 ☐ No 1 □Yes filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 📆 🗘 o Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical XXNurse Practioner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of 126/2009 NPE 1730335878 May 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1.0 OUP Baltimore Mb. 21229 Movales Caton Avenue 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ELMER 2009 Ame 5 /Medical 4c. County of Death City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner N/A BALTIMORE ALtimore en If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday Date of Birth (Month, Day, Year 9-15-1922 9. Birthplace (State or Foreign **Funeral** Days Months Hours MARYLAND 219-18-3312 86 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1 √Yes 2 No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 740 POPLAR GRAOVE ST. APT 4C 21216 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or items 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1∐Yes 2∭ZNo þ Specify: 3 X Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) -12-College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Monce. CLERK SOCIAL SECURITY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 LEVI HOLLEY MARIA HOLLEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES HOLLEY JR (SON) 702 VINE ST. BALTIMORE, MARYLAND 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation ☐Removal from State 4 Donation 5 Other (S ecify) BALTIMORE NATIONAL 6-4-2009 BALTIMORE, MARYLAND SONATHAN D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. Funeral Se 21. Signature ce License 1721-27 N. MONROE ST. BALTIMORE. MARYLAND 21217 23a. Parr / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shr k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme ar Cause (Final disease) r condition resulting in death) **Physician** Phumonia a weeks /Medical Due to (or as a consequence of): Examiner Pulmonary Chronic years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and Due to (or as a consequence of) attending physician for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No ed by the detached 9☐ Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 ☐ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No 24a. Was an has autopsy performed? 1∐ Yes 2 X No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 1 **n**patient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Il Director: / 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours and
To the Funeral Dir the

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year) State Registrar JUN 0 2 2009

30.

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

1	2	5	AZHEL	MER	CHANT	Me
Name and ac			, ,	- 4-	(Item 23a) (Type	

IDNORTH GREENC STREET BALTIMORE, MD 21201

1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 27, 2009 5:30 A May Margaret Anne Herren /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Bel Air Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2√2 F Ohio 2, 1931 Director 292-74-6855 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No **Funeral Director** Bel Air Maryland Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21014 201 D Fairwood 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 ☐ Yes 2 No Specify. þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) tt of Health and Mental Hy If item 27 is marked 17. Father's Name (First, Middle, Last) Be John Wesley Raines Margaret Anne Meyers ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 201 D Fairwood, Bel Air, MD 21014 William M. Herren / Husband Báltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Important: If it any Injury or o once. 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State 6-1-09 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. Towson, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Rd., Abingdon, MD 21009 21. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Rd., Abingdor

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Shock **Physician** Circulatory disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Pulmonary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of burial-transi Due to (or as a consequence of): Records, P.O. Box 68760 Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy Year Month Day signed by the at d be detached fo 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Acute failure renal page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform certificate 2 No 1 ☐Yes 2 ₺No 1 ☐ Yes the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending P 24 hours after death. Funeral Director: After t 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signatyre and title of certifier D 63420

Registrar

ubair

31. Date filed (Month, Day, Year)

0 2 2009

1, M.D. 500 Upper Chesaparke Dr. Bel Air, MD 21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 27 2009 10:40 A M May Clara Arther Huffington /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Upper Chesapeake Medical Center Harford Bel Air 8. Date of Birth (Month, Day, Year)
Sep. 17, 1 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min, 1 □ M 2 🕱 F Months Days Hours Director 217-18-9974 87 Maryland Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. m 27 Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examinat must be nutified at once. 1 ☐ Yes 2 X No Director Harford Churchville Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3101 Rolling Green Drive 21028 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 177/es 2 F]No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 📆 No Specify. Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Norman Ellis Arther Nellie McNeill Adair ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Norris J. Huffington Jr./Spouse 3101 Rolling Green Drive, Churchville, MD 21028 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Churchville Pres. Cem. 6-4-09 Churchville, MD 22. Name and Address of Facility McComas Funeral 21. Signature of Funeral Service Licensee Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-transi Dronovy Due to (or as a cons. quence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 menths? 1 ☐ Yes 2 ☑ No Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. è 2 1 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 s autopsy performe 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t fur era 5 Pending investigation 1 Natural 1 ☐ Yes 2 NO 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

ospital or Attending Physician: The law requires that the death certificate be executed Huffington Clarr MOCOORSES Division of Vital Records, P.O. Box 68760 the

uneral Directo within To the

> State Registrar

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

32. Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

0 2 2009

Mesuplate Dr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last, **Physician** AHNKE /Medical County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMOR INGHA 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** WEST Days 1 □ M 2 🗹 F VIRGINIA Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Experience rust be notified at 10a State 1 ☐ Yes 2 ☑ No Director (NGHAW 10g. Citizen of What Country? Zip Code 10e, Street and Number death with 21236 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 1 Dever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: þ Specify: 3 ₩ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/S, condary (0-12) College (1-4or 5+) BALTIMORE (XO. PUBLIC SCHOOLS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental h ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trausonce. 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 20a. Method of Disposition 1 M Burial 2 Cremation 3 Removal from State 2009 4 ☐ Donation 5 ☐ Other (Specify) IAKFORD FIOAD FARKVILLE, MD 21234 + CREMATION SERVICES-FARKVILLE 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or near tailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (a consequence of): Examiner Oronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a const uence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? ignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Certification: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Nown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 □Yes 2 12No 2 □ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

6 V

State Registrar

State 31. Date filed (Month, Day, Strar

30. Name

ess of person who completed cause of death (Item 23a) (Type, Print)

Sital Drive Suite & Uthidum

10 Day Year)

32 Registrar's Simature

DHMH 17 Rev 1/2001

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** William Edward Jones 6:45 2009 May 28 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Hospital Center Westminster Carroll Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9 - 7 - 1928 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 X M 2 □ F 219-22-1777 80 Yrs. Maryland **Director** Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it western Evan and the proces. 1X Yes 2 □ No Directo MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15 Park View Terrace 21157 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc Never Married 2☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Manufacturing Elementary/Secondary (0-12) College (1-4or 5+) Loader 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick Jones Rena Fuller ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jane Hai-sister Timber Ridge Dr. Westminster, MD 21157
isposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State All County Crem 5-31-2009 Sykesville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Fletcher Funeral Home PA 1 Chomas 1 E. Main St. Westminster MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician **ASCVD** disease or condition resulting in death) Years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Dause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 M/No 24a. Was an autopsy 1 ☐ Yes 2 12 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \[\text{Nursing Home} \] 1 \[\text{Residence} \] 6 \[\text{Other} \(\text{(Specify)} \) 1 Yes 2 No 1 🗌 Inpatient 2 R/Outpatient 3 DOA Certification: To After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deati To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO051924 May 29, 2009 27 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Herbert P. Henderson 2973 Manchester Rd. Manchester MD 21102 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	d / Department of H Certificate of I			g. No. 2009	17570
			Decedent's Name (First, Middle, Last)				Day Year	3. Time of Death
	Physicia /Medic		Margaret M. Jones			Month May	29 2009	3:32 AM
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Genesis HealthCare - The Pines Easton			4c. County of Death Talbot		
	_		Genesis HealthCare - The P 5. Social Security Number 6. Sex 7. Age (In yrs. la			8. Date of Birth		place (State or Foreign ntry)
	Funeral Director		214-42-6895 1□ M 2△ F 84	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day, 06/18/19	924 Mass	achusetts
	D		Usual Residence of Decedent					10d. Inside City Limits
	show	_	77	Town or Location				1 2 Yes 2 □ No
	he Ma	ecto	Maryland Prince George's Hya	10f. Zip Code		10	og, Citizen of What Cou	ntrv?
	with t	Funeral Director	4814 71st Avenue	20784	4		USA	•
	death with the Maryland rms 23a or 28a-f show		11 Marital Status 12. Was Decedent Ever in U.S			cify Yes or No-	14. Race - Ameri	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment in a to or content and the content and the medical at any injury or other traumatic event, the Medical Experiment in a to once.	by Fur	Armed Forces? 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 □Yes 2X No		nican, etc.)	Black, White, Specify:	White
21215-0036	72 hou	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	ation during most of workin	ng I	16b. Kind of Business/In	ndustry
121	ithin 7 ne. han "i	mple	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired Purchasing A			Federal Go	vernment
7	illed w Hygie ther ti		17. Father's Name (First, Middle, Last)	rurchasing A	18. Mother's Name	(First, Middle, N		
Jones Maryland d 2 should be file th and Mental Hy th same weent traumatic event To Be			Thomas G. Maloney Sr.		Helen I	rene Br		
Jone: larylan	shoul and M s mari umati	٦	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street	and Number or Rura	l Route Number,	City or Town, State, Zi	p Code)
Σ	and 2 salth a 27 is er tra		Edmund F. Jones, Jr Son	4814 71st Av				
rgaret altimore,	jes 1 t of He if iten		20a. Method of Disposition 1 StBurial 2 ☐ Cremation 3 ☐ Removal from State	lace of Disposition (Name of emetery, crematory or other pla	ce) D		20c. Location - City or T	,
ga. tim	t. Pag tment tant: ijury o		4 □ Donation 5 □ Other (Specify) For	t Lincoln Ceme			Brentwood,	
E DIOI Blademosti						, Brent	wood, MD 2	ноте 20722
9	Physician /Medical Examiner	ier	resulting in death) Due to (or as a consequence)	TAGE R	ENAL	DISH	-200800	Interval Between Onset and Death
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2009 m. JOHNSON 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE UNIVERSITY OF MARY LAND MEDICAL SYSTEM If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Months Days Hours New Hampshire 1 □ M 2 🖫 F 001-40-951 59 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2XXXVo Hedgesville Morgan 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 25427 40 Wandering Lane 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1√m2 Yes 2 □ No 197 If Yes, Give Year or Dates: 19 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1971-Never Married 2☐ Married 1 □Yes 2XXXNo White 1973 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Medical Physicians assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gladys Marion Adolf Johnson Milton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 40 Wandering Lane, Hedgesville, WV 25427 Patricia Crowl/Friend 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place Mt. Nebo Cemetery Date 20a. Method of Disposition MBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/1/2009 Great Cacapon, WV 22. Name and Address of Facility Helsley-Johnson Funeral Home, Inc. 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) FAIL WIRE STUNDARY ORGAN SYSTEM NUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of ARDIAC IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

WV

Director

Funeral

Completed by

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Medical Certification: To Be Completed by Physician/Medical Exami
completely filled in by the funeral director, page 2 should be detached for use as the buriar-tial is
Secret feigned out on the secretary and black and black of the secretary and the secretary of the secretary and the secr
To the Funeral Director: After this certificate has been signed by the attending physician and
within 24 hours after death.
To the Hospital or Attending Physician: The law requires that the death certificate be executed

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

ysiciai	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Ectopic preg Other (spec			Month Day Year		
a by FII	Part II. Other significant conditions	contributing to death but not resulting in the un	nderlying caus	se given in Part I.	23e. Did tobacc	o use contribute to the cause of death? 2 \(\)\(\)\(\)\(\)\(\)\(\)\(\)\(
oniplete					24a. Was an autopsy performed 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2		
פ	25. Was case referred to medical	26. Place of Death (Check only one)						
0	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 [5 ☐ Residence 6 ☐ Other (Specify)		
ation: I	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	f 280	thiury at Work? 1 ☐ Yes 2 No	28d. Describe how in	njury occurred		
)ertilici	3 ☐ Suicide 6 ☐ Could not be determined	building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
lical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my knowledge, death miner: On the basis of examination and/or in and manner stated.	h occurred at westigation, in	the time, date and place n my opinion, death occ	e, and due to the caus- urred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)		

State

Zeike

7itle of certifier

M18278

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. GREENE ST BALTIMORE MD

31. Date filed (Month, Day, Year)

29b. Signature apd

Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 242 tate of Mary lange 50 confine of the alth and Mental Hygiene 1 - For A State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 2:57 PM 2009 Iris Ann Kuhn /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Funeral 1 □ M 2 🛛 F Months Days Hours Min. 213-28-9683 Director 76 July 31, 1932 Maryland Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mertial Hygiene.
The marked other than "natural", or Items 23a or 28a-f show the tranmatic event, the Meatical Expriser must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location MD 1 □Yes 2√□No Director Harford Abingdon 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3001 St. Clair Drive #106 21009 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 <u>□ Yes 2</u> No If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: þ Specify: white 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 mail carrier post office 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leo Adam Hartman Agnes Matilda Becker ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Upper Chesapeake Medical Center 500 Upper Chesapeake Drive Bel Air, MD 21014 Important: If Item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages . ᇹ 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ronald 22. Name and Address of Facility Wade State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Baltimore, MD 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** 2000 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be execute burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 **A**No cas 1 ☐ Yes To the Hospital or Attending Physiclan: "within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1Æ\npatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number

State Registrar 30. Name and add

31. Date filed (Month, Day, Your)

DHMH 17 Rev 1/2001

founditris Ann MODOOD 740087

ss of person who completed cause of death (Item 23a) (Type, Print)

MOZAMON

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Year 2:06 AM 2009 June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Catonsville Baltimore Cammons atoms 8. Date of Birth (Month, Day, Sept 5, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 F Months Days Hours Min. Maryland 81 219-20-8458 Director Usual Residence of Decedent death with the Maryland 10h County 1∩a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show Director 1 ☐ Yes 2√ No Marvland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 16 Fusting Avenue 21228 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nt: If Item 27 is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: White ģ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Switchboard Operator Liquor Distributor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Rahe Katie Dahl 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles J. Kelly, Son 2905 Ridge Road Baltimore, Maryland 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 06/03/09 Baltimore, Maryland MacNabo Funeral Home, P.A. 21. Signature of Funeral Service Licepse Thomas Gregor Ju S Frederick Road Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or to consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last physician ar Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 m onths?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. à 3 Probably 4 → hknown 1 □ Yes 2 □ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Jas autopsy performed' of Vital 2 1No 1 🗆 Yes 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: Division s after dea. 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide A 24 hours the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

uren State Registrar

29b. Signature and title of certifier

er

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number ROS

Marshalee &

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 7:06 A M **Physician** 2009 31 May Louis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Country Care Assisted Living Finksburg 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Nov. 24, 1 5 Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days 1**X** M 2□ F 1909 Maryland 219-32-1277 **Director** Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is invited at 10c. City, Town or Location 10a. State 10h County 1 ☐Yes 2X No Finksburg Carroll MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 2716 Lawndale Rd. 21048 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ∐Yes 2 No Specify. If Yes, Give Year or Dates: <u>Ş</u> 3 ₩ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Sales Jeweler 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maggie Beck John Krauk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2716 Lawndale Rd., Finksburg, MD 21048 Robert Samuel Krauk-son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Winfield, MD South Carroll Crem. 6-6-09 22. Name and Address of Facility Fletcher Funeral Home, PA 21. Signature of Fureral rvice Licensee 254 E. Main St., Westminster, MD 21157 Approximate Interval Between Onset and Death 23a. Pard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition 445 **Physician** Gyonar resulting in death) /Medical Due to (or as a consequence A) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the eath certificate be executed burial-tran Box 68760. Due to (or as a consequence of): ending physician use as the burial IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery attend for use 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) signed by the a Tyes 2 No Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t irector, page 2 sl autopsy perform 2 □No 1 ☐ Yes 1 □Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2200 1 ☐ Yes မ this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: After Natural 5 Pendina 1 ☐ Yes 2 ☐ No investigation n 24 hours after death.

le Funeral Director: #
bletely filled in by the fi 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 2.

31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

Voyan Voyuela

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

29b. Signature and title of certifier

VATWALA 32. Registrar's Signature Bark

1130

29d. Date signed (Month, Day, Year)

6-1-09

3 celfinore Blvd Weetminstr MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 31 ^{Day} 2009 Year 4:25 P M **Physician** William Craig King /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Westminster Under 1 Year | If Under 24 Carroll Carroll Hospital Center 8. Date of Birth 3 - 9 - 19 49 9. Birthplace (State or Foreign 5. Social Security Number 212-56-9506 7. Age (In yrs. last birthday) **Funeral** Mary Tand Months 1 M 2 □ F Days Hours 60 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hyglene. ant: if tien at 71s marked other than "natural", or Items 23a or 28a-f show any or other traumatic event, it is it after that the property of the property or other traumatic event, it is it is after the arms to the property or other traumatic event, it is it is after the arms to the property or other traumatic event, it is it is after the property or other traumatic event, it is it is after the property or other traumatic event, it is it is a total than the property or other traumatic event, it is it is a total total than the property or other traumatic event. 28a-f show 1 ☐ Yes ¾☐ No MD Carroll New Windsor Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21776 1184 JoApter Place USA Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Accounting 12 Inventory 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Shirley Brauer George Lo'is King 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Margaret S. Brauer-mother 225 Frock Dr., Apt. 306 Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) South Carroll Crem. 6-1-09 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fletcher Funeral Home PA 21. Signature of Funeral Service Licensee thomas 254 E. Main St. Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** of un known Adano curcinoma resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine burial-transi that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be execu Due to (or as a consequence of): attending physician for use as the buris Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 D Ectopic pregnancy Month Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s autopsy perform 2 No 1 ☐ Yes 20X No 1 □Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital this c 1 Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day, Year) Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 🗌 Suicide determined 4 Homicide within 24 hours aft To the Funeral Di completely filled in tk Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar 212 washington Heights Med. Ctr; Westminster, MD 21157 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Babak Imanoel, DO;

parke

29c. License number

H53939

29d. Date signed (Month, Day, Year)

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 8:30 AM 28 Ellen Kraus Z 09 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Charlestown Care Center Baltimore <u>Catonsville</u> | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. 27, 1919 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 💢 F Yrs. Indiana 89 Director 172-12-7296 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. Count 10c. City, Town or Location 10a. State worle in then "naturel", or flems 23a or 28a-f ebox the Medical Examinar must be notified at 1 ☐ Yes 2 No Be Completed by Funeral Director Catonsville Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 713 Maiden Choice Lane 21228 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filed v Department of Health and Mental Hygies Important: If item 27 is marked other 11 ery injury or other traumatic event, III.s once. 02 Cosmetics 12 Executive Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Catt Delight Hopewell Edgar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Elizabeth Miller/Friend 12317 Falls Road, Cockeysville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 06/01/09 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial Gardens | Timonium, Maryland 21 Skinatus of Funeral Service Clary 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road, Timonium, MD 21093 23a. Part1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immedia e Cause (r nal disease er condition resulting in facility **Physician** neumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner nding physicien and use as the burial-transit to the Hospitel or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Be Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 💹 No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. vascular 1 Yes 2 No 3 Probably 4 to Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Peripheral Vascular Dementia 2 100 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours efter death To the Funeral Director: , completely filted in by the f 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1- Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (I em 23a) (Type, Print) Deneen Bowin, my Cotonsville, Lune, Maiden Choice 31. Date filed (Month, Day, Year) Registrar's Signature State back Registrar JUN 0 2 2009

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () () 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** FLORENCE 2009 11155AM 2 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Himore Hospita m D Birthplace (State or Foreign Country) (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🖼 F 215-30-975 Usual Residence of Decedent **Director** inia death with the Maryland 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or rother traumatic event, Its Marical Extension must be recitled at 1 Mes 2 No Director mD timore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 1800 Funeral 12. Was Decedent Ever in Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2 ☑No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Health lursc 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be grand 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Hone He Brown Norman daughter 5925 Western 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaughn C. 21. Signature of Funeral Service Licensee 5151 paltimore National Pike reen 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he at failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CHOZANO disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner IN FELTED Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy cate has been signed by the atter page 2 should be detached for in the past 12 months? Year Month 5 Other (specify) 1 □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MELLITU 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? DEMENT 2 No 1 □ Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours af To the Funeral Di 29a. Certifier 1 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Division of Vital Records, P.O. Box 68760

Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

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MD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PATEL

32. Registrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 0^{Year} **Physician** 31 May 7:05 PM Lindsay /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA Joseph Ritchie Hospice Baltimore 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) V A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Hours 1 □ M 2√2 F Months Days 216-54-4819 60 Director 11 - 27 - 48Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Exprinterment be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 Yes 2 □ No Director NA Baltimore MD 10q. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21223 1804 West Lexington Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify Black 1 ☐ Yes 2X No Specify: \$ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9th Grade Nurse Private Duty 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bibbens Annie David Clayton ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter Avenue Baltimore, MD 21217 2215 W. North <u>Janice R. Clayton</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 06-02-09 Metro Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Wylie Funeral Homes P.A. 638 N. Gilmor Street Baltimore, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. On not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final **Physician** 71510 O Months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and burial-trar Due to (or as a consequence of) Box 68760, attending physician for use as the buria The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐ Yes 2 No signed by the 9 Unknown 9 Unknown ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 ☐ Yes 2 🗹 No 1 ☐ Yes 2 🗆 No **Division of Vital** Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home Hospital: 1☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 Ø Other (Specify) Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director; 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated within 2 29b. Signature and title of ce 29c. License number

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of

31. Date filed (Month, Day,

Year)

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son who completed cause of death (Item 23a) (Type: Print)

s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** May 2009 7:59 P M John Lyles /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Baltimore City Joseph Richey Hospice | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, March 3, Birthplace (State or Foreign Country)unk 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** 1X M 2 □ F Director 220-72-7859 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, it of "notical Examination must be notified at 1 ☐ Yes 2K No Funeral Director MD Baltimore Catonsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21228 55 Wade Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status unk 1 ☐ Never Married 2 ☐ Married black Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2K No Specify. 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry**un** 16a. Decedent's Usual Occupation un 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien. Important; if Item 27 is marked other tha any injury or other traumatic event, Ital and once. unk 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) unk Be ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 838 N. Eutaw Street Baltimore, Maryland 21201 Joseph Richey Hospice Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5☑Other (Specify) in state 21. Sign through Funeral Service lice Ronal d S 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, Maryland 21201 Warte Director Baltimore, Maryland 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dyin, such a cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death to (or as a consequence of): Immediate Cause (Final **Physician** disease or condition resulting in death)) /Medical Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical attending pl IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) □Yes 2□No P.O. | the 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 6 known Completed page 2 should 24b Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe certificate 1 ☐ Yes 2 ☐ 26. Place of Death (Check only one) funeral director, 25. Was case referred to predical Be examiner; Other: 4 Nursing Home 5 Residence 2 | JK 1 Inpatient 2 ER/Outpatient 3 DOA 6 Dether (Specify) 1 ☐ Ye Certification: To After this 27. Mayner of D 1 Natural 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) er of Death 28b. Time of 28c. Injury at Work? Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death. To the Funeral Director; A 2 Accident filled in by the 6 □ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated. 29d. Date signed (Month, Pay, Year) 29c. License number 29b. Signature and title of certifie

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 7:14 PM 2009 MAY Lewis Irishteen /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner SAINT AGNES HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2√2 F Days 80 Director 216-24-3623 04 04 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 X Yes 2 □ No Funeral Director Baltimore MD NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21229 U.S.A. 4412 Frederick Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNo 14. Race - American Indian, 11 Marital Status Black White etc. 1 ☐ Yes 2 [X]
If Yes, Give
Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2**X** No Specify. Specify: Completed by Black Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland Cook 12th grade and Mental Hygies marked other the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be file tment of Health and Mental H tant: If item 27 is marked out Unknown Be 2 Estelle Boyd 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4412 Frederick Ave, Baltimore, Md 21229 Charles Smith-Grandson item 27 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/6/09 Zion Baltimore, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West ala 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** BILATERAL PHEUMOHIA DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): requires that the death certificate be executed burial-tran Due to (or as a consequence of): physician 68760 the aftending ph for use as th Box a esn IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.O. I detached 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed PSORIASIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate | Vital 1 ☐ Yes 2 ☐ No 1 □ Yes 2 No Physician: 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Medical Certification: To this Division of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 1 Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide filled in t Hospital 1 🔏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MID P21617 2009

State Registrar

(7)

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32. Reistrar's Signature

AVENUE, BALTIMORE, NO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

070SU

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Angela C. Lang 12:25a 2009 /Medical May 31 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Baltimore Stella Maris Hospice 8. Date of Birth (Manth, Day, Year) P 3 2 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2√2 F 212-30-5715 77 Director Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, I're Madical Evanian, included at Director Baltimore MD Essex 1 ☐ Yes 2 TXNo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? USA 625 George Avenue 21221 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2X Married 1 ☐Yes 2 No White Completed by Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Baltimore County Secretary 12th 17. Father's Name (First, Middle, Last) Be 18 Mother's Name (First, Middle, Maiden Surname) h and Mental P should be Elizabeth Teichman John Kurzmiller 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 625 George Avenue Balto. MD 21221 Pages 1 and 2 s ment of Health ar permit. Pages 1 and 2. Department of Health a Important: If item 27 is eny injury or other traionce. Norman Lang /husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oak Lawn Cemetery 6/4/09 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 MAce Ave. Balto. MD J Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** TONSIL CANCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 No Month Day Year signed by the a 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Completed 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy certificate 1 □Yes 2 No this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After 1 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Division of Vital Records, P.O. Box 68760.

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Maryland

Baltimore,

ithin 24 hours after death.

the Funeral Director: A
pmpletely filled in by the fu within 2.

To the F

State Registrar

Medical

29b. Signature and title of certifier

3 Suicide

4 Homicide

6 Could not be determined

oneX Nurse Practitionerner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

TIMONIUM, MD 21093

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10a-c.e.f.11.17.perFH.G892,6/2/09.WS

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death A. M Month **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE Birthplace (State or Foreign Country)
 MD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/23/1927 5. Social Security Number 6. Sex 1 🕻 M 2 🗆 F 7. Age (In yrs. last birthday) **Funeral** Days 216-20-0456 82 Director Usual Residence of Decedent 10b. County Palm Beach Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Beach Gardens 10d. Inside City Limits 10a. State or items 23a or 28a-f show r than "natural", or items 23a or 28a-f sho 1 ☐ Yes 2 No Director OWINGS MILLS BALTIMORE 10f. Zip Cod 3410 10g. Citizen of What Country? 10e. Street and Number dens Parkway #503 USA Funeral . Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify ò Specify 3 ☐ Widowed + ★ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Health and Mental Hygiene. CERTIFIED PUBLIC ACCOUNTANT ACCOUNTING permit. Pages 1 and 2 should be filed will be partment of Health and Mental Hygien Important: If Item 27 is marked other than y Injury or other traumatic event, the other. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leikin LIEKIN ROYAL FRANCES LEIBERMAN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) EDWARD LEIKIN / SON 11101 HIDDEN TRAIL DR., OWINGS MILLS, MD 21117 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State HAR SINAI CONG. 05/31/2009 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760 Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) signed by the a d be detached for I ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been si e 2 should l 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an r this certificate has ral director, page 2 autopsy performe 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation after death.

I Director: A id in by the fu death. 1 ☐ Yes 2 ☐ No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number ed cause of death (Item 23a) (Type, Print) 30. Name and address of person B 31. Date filed (Month, Pay, Year)

DHMH 17 Rev 1/200

State

Registrar

32. Registrar's Signature

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State Registrar 1. Decedent's Name (First, Middle, Las	State of Ma		•	rtificate of D			eg. No.	009	3. Time of Death
Physicia /Madia		CATHERINE	,,,		MORR	IS		MAY 29,	Dav	Year	5:40 P M
/Medic Examine		4a. Facility Name (If not institution, give HOSPICE OF QUEEN	e street and number) ANNE 'S HOSPICE HO			4b. City, Town, or CENTREV	ILLE			ty of Deatl	
Funeral Director		Social Security Number 6. S		e (In yrs. las 87	yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, 11/22/19	Year)	9. Birti Co.	hplace (State or Foreig untry)
Ba-f show	ctor	UsualResidence of Decedent 10a. State 10b. County MD Baltimo	re		Town or Lo	cation					10d. Inside City Limits
23a or 2	Funeral Director	10e. Street and Number 7728 Bennerton D	rive			10f. Zip Code 21236-	3901	1	0g. Citizen o USA	f What Co	untry?
do the trygene. do the than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 45 ⊅ pivorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give X Year or Dates:			Was Decedent of His If Yes, specify Cubar 1 □Yes 2ሺ No		ecify Yes or No- Rican, etc.)	BI	ace - Ame lack, White cify: Whi	
an 'natur Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5		16a. Dece (Give life.	dent's Usual Occupa kind of work done d DO NOT use retired)	tion uring most of work	ing	16b. Kind of		
n and mental hygien Is marked other tha raumatic event, the	Be Con	9 17. Father's Name (First, Middle, Last)		S	ecret		18. Mother's Name				Co.
s marked o	To B	william Harvey Shifteff Featl J. Knight						in Ctate "	Zin Cada)		
Department of nearing and wenter Important: If item 27 is marked any Injury or other traumatic eventer.		19a. Informant's Name/Relationship (Delores A. Mo 20a. Method of Disposition	rris(DTR)		7728	Bennerton sition (Name of natory or other place	Drive,	Baltimon Date	ce, Md	. 21	236-3901 Town, State
mportant: If		Timons Signature of Funeral Service icensee 22. Name and Address of Facility Schimunek Funeral 9705 Belair Road, Nottingham, Mo									
ng physician and as the burial-transit	-	Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a conseque	nce of):	ile Dom	ontia				
certificate has been signed by the attending phy rector, page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal d	leath 3[☐ Ectopic pregnancy ☐ Other (specify)				Date of del	ivery Day Year
in signed build be deta	þ	Part in Other significant continuous contributing to death but not resulting in the underlying cause given in Part i.									
cate has bee	Completed							24a. Was a autopo perfor 1 🗆 Yes	med?	prior to death?	utopsy findings availab completion of cause of 2 □ No
is certif director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	ent 2□El	R/Outpatie	nt 3 DOA Othe	26. Place of Deat	th <i>(Check only or</i>		Other (Spe	city) Hospice (
To the Funeral Director: After this certific completely filled in by the funeral director.	Certification: T	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide	28a. Date of Inju (Month, Da	ary 2 ay, Year)	8b. Time o Injury	f 28c. Injury Work	at	28d. Describe h	ow injury occ	urred	ural Route Number,
ne Funeral	Medical C		nysician: To the best niner: On the basis of and manner st	of examination							
To th	Me	29b. Signature and title of certifier , L. Quant 30. Name and address of person who TOLING, ARRIMS 31. Date filed (Month, Day, Year) JUN 0 2 200	ad In	Wis.		29c. License	2000	İ	11	1	h, Day, Year)
		30. Name and address of person who	completed suse of d	death (Item 2	23a) (Typ <i>e</i> ,	Print)					

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydiene

2009 17585

teven Moore	1	State of Maryland / Department of Health and Mental Hygiene 2005 175 - For State Certificate of Death Reg. No.
Dhyninia	R	egistrar 2. Date of Death 3. Time of Death
Physicia Nedical Examin		Steven D. Moore May 28, 2009 1812 hrs
	4	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel
		Dailtimore Washington Medicar Center Control of Part Politics Part Politics
Funeral Director	- 1	Months Days Hours Min. Country)
Director		220-86-3319 1X M 2 F 40 Yrs. World September FEB 6, 1969 Maryland
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
* "	-	MD Anne Arundel Severn 1 Yes 2 X No
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
15-0036 filed within 72 hours after death with the Maryland I Hygiene. at other than "natural", or items 23a or 28a-f sho t, the Medical Examiner must be notified at once.		7981 Telegraph Road, # 21 21144 USA
th with	Funeral	11. Marital Status 1
\$ 5E	Fu	1 Yes 2 X No 3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify: White
urs aft tural"	<u>a</u>	15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry
72 hor	etec	Elementary/Secondary (0-12) Coillege (1-4 or 5+)
vithin ene.	Completed	12 Truck Driver Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", e event, the Medical Examiner		17. Father's Name (First, Middle, Last) John D. Moore 18. Mother's Name (First, Middle, Maiden Sumame) Catherine Stein
2121 uld be fi Mental marked	To Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Baltimore, MD 21 pernit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other tranmatic ev		Vicki V. White, cousin 1296 Sheridan Road Crownsville, MD 21032
Te, f I and Health Fitem		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State
Pages rent of		Metro Crematory, Inc. 03/30/09 Ball linore, mb
Baltimore, permit. Pages La Department of He Important: If ite		21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc.
	_	299 Frederick Road Baltimore, MD 21228 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Petworp Open and
Physician 'Macical		failure. List only one cause on each line. Occlusive Pulmanary Thromboembolism Death
.aminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):
2.0		Sequentially list conditions,
	ine	If any, leading to immediate Dub to (or se a consequence of)? cause. Enter Underlying Cause
_ ,=	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	a E	d.
O, be ex	edical	UNPENDED AMENDED 236 If you cutsome of prepapacy 236 If you cutsome of prepapacy 237 If you cutsome of prepapacy
Box 68760, e death certificate be the attending physic ed for use as the burner of the burner at the		23b. Was decedent pregnant in the 1 ive high a Fetal death 3 Ectopic pregnancy Month Day Year
x 6 or cer or use	sicia	past 12 months? 4 Pregnant at time of death 5 Other (Specify)
. BC he dea y the a	Physician/N	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
i, P.O. B ires that the d signed by the	by	Cardiomegaly 1 Yes 2 No 3 Probably 4 V Unknown
cords, law require has been signal	Completed	24a. Was an 24b. Were autopsy findings available
COL slaw r shas b	mpl	autopsy prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
Vital Rec ysician: The l his certificate		25. Was case referred to medical 26.Place of Death (Check only one)
Vita ysiciai his cer direct	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other:
n of value Phy. After the funeral	-	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
ion itendi	atio	1 V Natural 5 Pending 1 Yes 2 No
Division of Vital Records, pital or Attending Physician: The law requirours after death. reral Director: After this certificate has been sfilled in by the funeral director, page 2 should the control of the control o	ertification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)
Spital hours rineral y fille	C	4 Homicide determined (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
To the Hospital within 24 hours To the Funeral	Medical	(Check only) One) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
To the within To the comple	Med	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	200	O.C.M.E. May 29, 2009
2 1/		30. Name and address of person who completed cause of death (Item 23a)
3 V		Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
S Regis	tate	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2009 Year Month 05 6:30 PM DIANE FLORENCE MEWSHAW /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 833 Deering Rd. Arundel Pasadena Anne 8. Date of Birth (Month, Day, Year) 9/28/1924 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours 1 □ M 2 ■ F 84 214 20 3626 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Director MD Anne Arundel Pasadena 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 833 Deering R. 21122 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 M No Black White, etc. 1 ☐Yes 2 █ If Yes, Give Year or Dates 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify: 3 ₩ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Substitute Teacher Catholic School 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ဂ Andrew Suski Victoria Rabitt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 833 Deering Rd Gail Mewshaw - Daughter Pasadena, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State MD Veterans Cem 6/2/2009 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility GJ Gonce Funeral Home, I 21. Signature of Funeral Service Lice Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequite of): Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent prognant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown -24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform 2 No 1 Yes 25. Was case referre medical examiner? 26. Place of Death (Check only e) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes / 2 | No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

The law requires that the death certificate be executed sician and burial-trans Box 68760, attending physician for use as the burial signed by the a d be detached for Division of Vital Records, P.O. certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, to

Physician

Examiner

Funeral

Director

show

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Expositive small be swifted at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item Z7 is marked other than " any injury or other traumatic event, If a IMM any once.

Physician

Examiner

/Medical

Maryland 21215-0036

altimore,

Examine Physician/Medical \$ Completed Be Certification:

Medical

State Registrar 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

27. Manny of Death 1 Watural 5 Pending investigation 2 Accident 6 ☐ Could not be 3 Suicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

4 Homicide 29a. Certifier

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Glen Burnie, MD

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

21061

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 0 2 2009

(Check only one)

7575 Ritchie Hwy 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2009 **Physician** ROBERT MICHAEL MERSON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ANME ECH BERNIE BALTIMORE KLOSHINGTON MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/24/1948 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min Days 1 **☑** M 2 ☐ F Maryland 219-52-4119 61 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eveniner must be notified at once. 1 ☐ Yes 2 No Director MD Anne Arundel Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21226 U.S.A. 8212 West End Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1968 14 Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🗹 No If Yes, Give Year or Dates: Specify. Specify: 1970 White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Glass Industry Supervisor/Glass Cutter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Whitehead Augustus Merson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8212 West End Drive, Baltimore, MD 21226 Margaret M. Merson/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 06/02/09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility G.J. Gonce Funeral Home, PA 21. Signature of Eureral Service Licensee Riviera Drive, Pasadena, MD 21122 169 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consecuence of): Physician/Medical Examine burial-trar Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☑ No 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗹 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 □Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed physician a the burial Division of Vital Records, P.O. Box 68760, attending p for use as t been signed by the should be detached After this certificate has funeral director, page 2 s

show

Medical

State Registrar 29a. Certifier (Check only one)

and title of certifie 29b. Signatus

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month Day, Year)

and address of person who despleted cause of death (Item 33a) (Type

31. Date filed (Month,

32. Registrar's Signature

09-03920 Robert Myrick, II

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009

,		1- For State Certificate of Death	Reg. No.
Physicia ledical Examin	7 1	1. Decedent's Name (First, Middle,Last)	2. Date of Death Month Day Year May 17, 2009 3. Time of Death 0556 hrs
ieulcai Examini	4	Robert N. Myrick Jr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Locat	
		2026 Larkhall Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or	
Funeral Director	6	219-08-2160 1 M 2 F 39 Yrs. Months Days H	Hours Min. 7 - 1-1969 Foreign Country) MS
any	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
ž .	5	MD Baltimore Dundalk	1 Yes 2 No
5-0036 ed within 72 hours after death with the Maryland lygiene. other than "matural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.	Dire	10e. Street and Number 10f. 21p Code 2026 Lark Kall Road 2122	
leath with r items 23 nust be no	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic 14. Was Decedent of Hispanic 15. Was Decedent Ever in U.S. 16. Yes, specify Cuban, Mex	xican, Puerto Rican, etc.) White, etc.
after crall, or	Ā.	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specific parts:	
"natural",		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	NOT use retired)
21215-0036 John Parish and The Mental Hygiene. marked other than "natural", event, the Medical Examiner	Completed	12 Disabl	E ()
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	٥	17. Father's Name (First, Middle, Last)	lother's Name (First, Middle, Maiden Surname)
2121 ald be i Mental marke	o Be	Robert N. Murick Sa. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and	d Number or Rural Route Number. City or Town, State, Zip Code)
nore, MD 2 ges 1 and 2 shou nt of Health and N t: If item 27 is n other traumatic	- 1	Barbara Murick - Mother 1224 Marte	ry, Date 20c. Location - City or Town, State
ore, s 1 and of Heal of Heal		20a. Method of Disposition 20b. Place of Disposition (Name of cemeter crematory or other place)	ry, Date 2uc. Location - City or Town, State
		4 Donation 5 Other Specify: Bayview Cremato.	suf5-21-04 Baltimore MU
Balti permit. Departir Imports	-	21. Signature of Funeral Service Licensee	1134 11), 110W SWING ROAD 21222
Physician	+	1 Burial 2 Cremation 3 Removal from State Crematory or other place) 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Funeral Service Licensee 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such failure. List only one cause on each line.	h as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and
ride dical xaminer	H	Immediate Cause (Final disease a. Difluoroethane toxicity	Death
		or condition resulting in death) Due to (or as a consequence of): b.	
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Course Enter Underlying Course	1
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
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60, ate be ex obysician	Medical	IF FEMALE: AMENDED	2 6/26/09 TT
3876 rrificat ling phy			Ectopic pregnancy Month Day Year
Box 687 e death certifit the attending of	/sician/	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify)	
O. En at the d	/ Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	
S, P. ires th n signe d be de	Completed by		1 Yes 2 No 3 Probably 4 ✔ Unknown 24a. Was an 24b. Were autopsy findings available
ord: aw requas bee	plet		autopsy prior to completion of cause of death?
Rec The I	S	26 Place of	1 ✓ Yes 2 No 1 ✓ Yes 2 No Death (Check only one)
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of V ng Phy Mer th meral d	n: 70		
ion ttendir death. ctor: A	atio	Natural 5 Pending Fd 5/17/09 Fd 5:52 am 1 Yes	2 XNo unk ding, etc. 28f. Location (Street and Number or Rural Route Number, City
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Certification:	Accident acc	or Town, State) 2026 Larkhall Rd Dundalk, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi			and place, and due to the cause(s) and manner as stated.
Fo the vithin ?	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, de and manner stated.	
	Ž	29b. Signature and title of certifier 29c. License n O.C.M.	47 0000
		30. Name and address of person who completed cause of death (Item 23a)	
Ø v		Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MI	D 21201
		a 31. Date filed (Month, Day, Year) 32 Registrar's Signature	
Regis	urali	TIN 0 a 2009 Version of a contract	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] S Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 7,2009 Month **Physician** MARTHA A. MAKIN /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner itizens ursina Home Date of Birth (Month, Day, Year) Hours 1 □ M_2 🛛 F 205-12-9037 85 June 14, 1923 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits 1 ☐ Yes 2 No Directo Maryland Cecil Conowingo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 117 Tulip Drive 21918 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐No 3 Specify. 3€ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kathryn LeGrand Heckman S. McKelvey Edward ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rob ert D. Makin / Son 117 Tulip Dr., Conowingo, MD 21918 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Hilltop Service Corp: 5-30-09 4 Donation 5 ☐ Other (Specify) Towson, Maryland 21. Signature of Fugeral Service Licenses 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1☐Yes 2☐No 9☐Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 20100 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA P ◆☑Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide 🛪 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier

Examiner lakin, Martha A. Division or Vital Records, P.O. Box 68760, To the within 2

certificate be executed ng physician and as the burial-tran cale has t een signed by the attending physician page 2 should be detached for use as the buna completely filled in by the funeral director, To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After

Funeral

Director

r 28a-f show notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be I

Physician /Medical

3altimore, Maryland 21215-0036

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier Burch

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day Year)

30. Name and address of person who comp

32. Registrar's Signature 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mety Mary Jane Neighbours 30^{Day} 2009 6:30 A. **Physician** /Medical 4a. Facility Name (If not institution, give street and number)
1555 Corbett Road 4c. County of Death 4b. City, Town, or Location of Death Examiner Manktan Harford County If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day May 31, 1920 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours Months 395-14-9743 1 □ M 2X F 88 Yrs Maryland Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It is Marical Exeminating any once. Maryland Baltimore County Manktan 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 21111 10e. Street and Number 1555 Corcett. Road United States of America Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Specify: White 1 ☐ Yes 200 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married aryland 21215-0036 1 ☐Yes 2X No Specify: Completed by 3√XWidowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1,4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George William Sattler Alice Reeney Wolfe ဥ 19h Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print)

J. Owen Neighbors (Son) timore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State June 1, 2009 Forest Hill, Maryland Evans Funeral Chapel 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services - Monkton 16924 York Road Monkton, Maryland 21111 21. Signatur If Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one of each line. Immediate Cause (Final tic Cardio vascul **Physician** Ateniosclero disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (_iecase of i july that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths?

1 Yes 2 No
9 Unknown Month Day Year 5 ☐ Other (specify) the cate has been signed by topage 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ★No 24a Was an certificate has autopsy performed? funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death

To the Funeral Director: the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mble H:11CT. Luther ville, Md 21093 tello 32. Registrar's Signature Day, Year) 31. Date filed (Month, State JUN 02 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Dominick R. Nicolette 2009 6:50P MAY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Saint Joseph Medical Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Davs 1 ★M 2 ☐ F 83 Director 215-22-2192 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exeminar must be notified at 1 SYes 2 No Director Dundalk Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21222 230 Patapsco Avenue Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ∏Xes 2 If Yes, Give 1 ☐Yes 2 🛣No Specify: White þ res, Give Year or Dates Korea 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) s 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Telephone Co. Janitor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rosa Missena John Nicolette 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1903 Tyler Road, Dundalk, MD 21222 John Nicolette - Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Rosedale, 6--2-09 Gardens of Faith 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bradley-Ashton Funeral Home 21. Signature of Funeral Service I PA, 2134 Willow Spring Road, 21222 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** DAYS disease or condition resulting in death) SEPSIS /Medical Due to (or as a consequence of) Examiner DAYS RENAL FAILURE ACHTE Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consequence of Exami and Due to (or as a consequence of) attending physiciar Physician/Medical the nse If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Month Day Year 5 Other (specify) signed by the a d be detached f 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 ☐ Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 ■ No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Anpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

certificate be executed Box 68760, P.O. Records, Division of Vital

Baltimore, Maryland 21215-0036

To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu State Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of-certifier D25886

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

DRIVE TOWSON, MARYLAND

31. Date filed (Month, Day, Year) JUN n ~ 2000

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month **Physician** 3:36 BW MAY 30,2000 BACTAZAR UAVADU /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner SIEN BURNIE IBOUWAA MUAA BALTIMORE-WASHINGTON MEDICAL CENTER B. Date of Birth (Month, Day Year) Dec. 28,1928 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 1 XM 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 80 Philippines 586-60-7115 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Anne Arundel Directo MD Severn 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21144 U.S.A. 7825 Stateman Street Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 MYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Filipino Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Engineer Westinghouse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Susana Carino Udaundo Ponciano Ngayan မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7825 Statesman Street Severn, MD 21144 Mrs. Trinidad Ngayan/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 💢 Burial 2 □ Cremation 3 □ Removal from State Arlington National Cem. 7/1/2009 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Lice Services, PA.; 1 2nd Ave SW Glen Burnie, MD 21061 23e. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final 20445 **Physician** AugoMU349 disease or condition resulting in death) /Medical Due to (or es a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and iis certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-trai Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (specify) □Yes 2□No 9 | Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 32A32KG YASTAA YAANOAO Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 KNo 2 No 1 ☐ Yes 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 X No 1 KInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital of within 24 hours af To the Funeral D completely filled in 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier De Com Dornes Jose Cuano pour, MD 100053314 MAY 30, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CUILLER HO JOSE GIANGRECO 301 HOSPITAL DRIVE, GLEN BURNIE, MD 20161 31. Date filed (Month JUN 0 2 2009 32 Registrar's Signature State parker Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 for State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Z 0001 -Month **Physician** Bette Obitz June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Glen Burni Baltimore Washington Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Vear Hours Min. 1 □ M 2**X** F Days 541-26-4325 **Oregon** Director 86 SEP 8. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show event, the Medical Examiner must be nutified at 1 ☐ Yes 2 No Director Anne Arundel MD Severn 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö **USA** 21144 1343 Burlington Drive items 23a Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 0 1 ☐Yes 27 No Specify þ 3 ₩ Widowed 4 Divorced White 'natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 National Guard Secretary 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Heath and Mental Hy Important; If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) Be Clarence Trevathen Elenor Pedersen ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kathy Devan/Grand Daughter 1870 Cedar Drive Severn, MD 21144 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. 6/2/09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee C. Todd Dring Cremation Society of Maryland, Inc 299 Frederick Rd Baltimore, MD 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final m 9 ms **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Granulomatos) Examiner -CF M Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as nsequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) signed by the a Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 2 No 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 No 1 🗌 Yes 1 □Yes 2 □ 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 🗆 No death. 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral TS Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of co 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 OFi 31. Date filed (Month, Day, State Registrar

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Malcolm Stacey Oliver	State of Maryland / Department of Heal

th and Mental Hygiene

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		1- For State Registrar		Ce	rtifica	te of	Death			R	eg. No.				
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/ledical Exan										1652 hrs					
		4a. Facility Name (if not institution	,			4t	c. City, Town, or	Location o				County of	f Death		
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Funera		5. Social Security Number	6. Sex	7. Age (In yrs.	last birth	day)	If Under 1 Year	If Under	r 24Hrs.	8. Date of Bi	rth(MM/E	DD/YYYY)	9. Birth	place (State or	\neg
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7293 72 hours after death with the Maryland natural", or items 23a or 28a-f she	Funeral Director	11. Mantal Status		cedent Ever in U	J.S.		Decedent of His				0-			an Indian, Black,	_
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5-003 led withi Hygiene. other the	5	17. Father's Name (First, Middle	. Last)		_		Т	18.Mother	s Name (First, Middle,	Maiden :	Surname)			
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Ore es 1 g of He of His		1 X Burial 2 Cremation	n 3 Removal f			ry or othe		,							
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Physicia	n	23a. Part I. Enter the disease, or		caused the deat	h. Do not	enter the	e mode of dying,	such as ca	ardiac or	respiratory ar	rest, sho	ck, or hea	art	Approximate Interv Between Onset an	
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8760, ifficate bug physic	Ne Ne	IF FEMALE: 23b. Was decedent pregnant in t	L- - '	outcome of pre							230	d. Date of			
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Records, P.O. Box 68. The law requires that the death certific cate has been signed by the attending money, a bound the death of the de	5	Part II. Other Significant condi	tions contributing	to death but not	resuming	ill the or	idenying cause (giveiriirea	11 (1.					ably 4 🗸 Unknow	m
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Division of Vital Records, rate day require rs after death. After this receitions has been sind in burst for a fewer of the state of th	Com	25. Was case referred to medica	al I				26 Place	of Death	(Check o		Z		V 10	2 110	
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of Vi	∄ ⊢	1 Yes 2 No 27. Manner of Death	28a Date	of Injury		ime of In		ry at Work		28d. Describe					
Johns	ijë	1 V Notural	(Mont	h, Day,Year)	200, 1	illie or ill		Yes 2		zou. Describe	s now my	ary occur	-		
tten tten ttor:	ੂੰ ਜ਼ਿੱ	- Fell	ding estigation					162 7							
or A of A Direction of the contraction of the contr	<u> </u>		ild not be	ce of Injury - At	home, fai	rm, stree	t, factory, office t	ouilding, et	.c. 2	28f. Location or Town.		ind Numb	er or Ru	ral Route Number, C	lity
Division of A Hospital or Attending Ph 24 hours after death. Funeral Director. After t	Certification:	4 Homicide dete	ermined (Specify)											
F F F	5		hysician: To the be												
To the Hospital within 24 hours To the Funeral Township 61110	Medical	one) 2 Medical Exa	aminer: On the basis and manner	of examination stated.	and/or in	vestigati	on, in my opinior	, death oc	curred at	the time, date	e and pla	ace, and d	lue to the	e cause(s)	
F 2 F 8	∛ §	29b. Signature and title of certifi		ototo o.			29c. Licens	e number			29d.	Date sign	ed (Mo	nth, Day, Year)	
		(Vara)					O.C.	M.E.			May	y 28, 20	009		
		20 Name and address of account	n who completed se	ico of dooth /li-	m 23c)	_									
		30. Name and address of person Ana Rubio MD. As:	n wno completed cat sistant Medical			enn S	treet, Baltime	ore MD	21201						
				egistrar's Signa	tura.			,							
		- v., Dale Heudynnii Dav (687)													
	State istrai			una 1	1	par	مسك								

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 10, 2009 Adrianna Perez 1:30 AM M 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Pptince George's 3334 Buchanan Street Mount Rainer If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)unk 5. Social Security Number Unk 6. Sex 7. Age (In yrs. last birthday) Days 1 □ M 2 🖾 F March 15, 74 Usual Residence of Decedent 10d Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Mount Rainer Prince George's 10g. Citizen of What Country? unk 10f. Zip Code 10e. Street and Number 3334 Buchanan Street 20712 13. Was Decedent of Hispanic Origin? (Specity Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status unk 12. Was Decedent Ever in U.S. Armed Forces? unk 1 □Yes 2 □ No 1 ☐ Never Married 2 ☐ Married 1√2 Yes 2 No Specify: Specify: white If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation unk (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk 19a. Informant's Name/Relationship (Type. Print) Prince George's Police Dept. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) In State State Anatomy Board 655 West Baltimore Street Baltimore, Maryland 21201 21. Signature of Funeral Ser Ice Licensee 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate sause (Final disease or condition resulting in death)

a. A SCOSSILVENCE of the condition resulting in death) Approximate Interval Between Onset and Death Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of). If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 🔲 Ectopic pregnancy Month Dav Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 □Yes 2 □ 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work?

/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760, ed by the detached signed by peen has certificate this After

Examine Physician/Medical þ Completed Be Certification: To within 24 hours after death.

To the Funeral Director: Aft Medical

Physician

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mertal Hyglene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show uny or other traumatic event, It. Muches I and It. In the Internation of the traumatic event, It. Muches I are not in the notified at

permit. Pages 1 and 2: Department of Health a Important: If item 27 is any Injury or other trauonce.

Physician

Baltimore, Maryland 21215-0036

/Medical

10a. State

MD

Director

Completed by Funeral

Be 2

> IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
>
> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

31. Date filed (Month, Day,

3001

32. Registrar's Signature

30. Name and address of person who concleted cause of death (Item 23a) (Type, Print)

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 05 29 2009 11:00pM Edward Payne Sr. Donald /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Pikesville Milford Manor Nursing Home Birthplace (State or Foreign Country) If Under 1 Year Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Min Months Days 1**⊠** M 2□ F Yrs 219-28-0523 75 Director MD Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location Show 10a, State 10b. County d other than "natural", or items 23a or 28a-f shovevent, the Medical Examiner must be notified at YYes 2 □ No Baltimore Director MD NA 10g. Citizen of What Country? 10e. Street and Number 21216 U.S.A. 2404 Harlem Ave Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14 Bace - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 √ No Specify. Specify: þ Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mail Carrier U.S. Postal Service f Health and Mental Hygier them 27 Is marked other the other traumatic event, Inc. 12th grade lyr 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Mae Greenfield Edward Payne 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Christine Kendall- Guardian permit. Pages 1 and 2 Department of Health Important: If Item 27 any injury or other tra once. 2404 Harlem Ave, Baltimore, Md 21216
ce of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 6/5/09 Woodlawn, Md 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, Md 21215 Immediate Cause (Final disease or condition resulting in death) MISEASE +THE ROSCLEROTIC CEREBRO VASCULAR **Physician** /Medical Due to (or as a consequence of): Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed bunial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician the burial Physician/Medical attending p 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be lirector, page 2 sl autopsy performed 2 No 1 □ Yes 2 □ No 1 □Yes director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manper of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No after death Director: / 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide n 24 hours aft le Funeral Di bletely filled ir Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) AVE, SUITE 23, CAVIHANI, mi) 2835 SmITH 31. Date filed (Month, Day, Year) 32 State

Registrar

JUN 02

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Raymond Phillips 8:10 23 2009 05 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore University of Maryland Medical Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Oct | Month | Days | Year 947 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number West Virginia **X** M 2 □ F 577-64-4611 61 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County tXXYes 2 □ No Waldorf Charles 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20603 11063 Lake Shore Court 12. Was Decedent Ever in U.S. Armed Forces? ••• Tyres 2 □ No 1476s, Give Year or Dates: Vietnam 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 🏋 Married 1 ☐ Yes 2 📆 🐪 o Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Newspaper Mailer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Metz Phillips Esther Margaret William Charles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11063 Lake Shore Court, Waldorf, MD 20603 Barbara J. Phillips/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place Greenway Cemetery) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Qurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 5/30/2009 Berkeley Springs, WV 22 Name and Address of Facility Helsley—Johnson Funeral Home, Inc. 21. Sign ure Funeral Service Licensee M00522 95 Union St., Berkeley Springs, WV 25411-1855 23a. Part 1. Enter the difference or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final LAVESIVE lun disease or condition Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Year Month 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Obstructive Pulmone 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

Physician /Medicai **Examiner**

and

attending physician

ned by the atter detached for u

funeral director, page 2 should be

24 hours after death. Funeral Director; A

within 24 hor To the Fune completely fi

filled in by the

Physician

/Medical

Examiner

10a. State

MD

12

Director

Funeral

þ

Completed

Be

2

Funeral

Director

in than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important; If item 27 is marked other the any injury or other transmests.

Baltimore, Maryland 21215-0036

Examine Be Completed by Physician/Medical Medical Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? □Yes 2□No 9 Unknown

1 X Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 5 Pending investigation

6 ☐ Could not be determined

2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

28d. Describe how injury occurred

2XX\\0

24a. Was an autopsy perform

1 ☐ Yes

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

1 ☐ Yes

2 🗆 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Arosemena, M. D ar) 32. Registrar's Signature 31. Date filed (Month, Day, Year)

JUN 0 2 2009 1 Mens 22 South Greene Street, Baltimore, MD 31201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ For	eartment of Health and Mertificate of Death	ental Hygie Reg.	211119	17598
4			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici		Patricia Phillips		May 2	Pay 2009	1035 M
marky.	/Medio		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deatl	
1	LAGIIII	ie.	Baltimore Washington Medical Center	Glen Burnie		Anne Arun	nde1
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birtl	nplace (State or Foreign
	Director		212-42-1136 1 M 2 D F 65 Yrs.	Months Days Flours Will.	(Month, Day, Ye Nov. 5, 1	1943	MD
	p ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	agation			10d. Inside City Limits
	arylan show	٦					1 ☐Yes 2X No
	he M	Director	MD Anne Arundel Glen Bu	nie 10f. Zip Code	100	Citizen of What Co	intry?
	a or		3 Chain O'Hills	21060		U.S.A.	,
	ns 23	era			cify Yes or No-	14. Race - Ame	rican Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Modical Examiner must be notified at once.	by Funeral	Armed Forces? 1 □ Never Married 2 Married 1 □ Yes 2 No 1 □ Yes 2 No 1 □ Yes (Sive Year or Dates:	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto f 1 ☐ Yes 2 ☒No Specify:	Ricán, etc.)	Black, White	•
2-0	72 ho	sted		edent's Usual Occupation e kind of work done during most of workir		. Kind of Business/	ndustry
21	thin le.	Completed by	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)			
2	ed w lygiei ner th			naker 18. Mother's Name		Own Home	
and	be fill	Be	17. Father's Name (First, Middle, Last) Charles Callahan	Marie S		dell Sulliame)	
Σ	d Me d Me narke	은		ling Address (Street and Number or Rura		ity or Town State 2	(in Code)
Maryland	d 2 sl th an 17 is i		, (),	nain O'Hills, Glen		-	.p code)
Ġ,	1 an Heal tem 2			position (Name of ematory or other place) June		Location - City or	Town, State
timore,	ages ent of it: If i			ven Mem. Park 2009		len Burnie	e. MD
Ē	mit. F partm nortar Injur		21. Signature of Funeral Service Licenspe	22. Name and Address of Facility Sin			
•	e a m e		Mark M. Varen MO1357	Servcies PA 1 2nd A	ve. SW G1	Len BUrnie	e, MD 21061
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or its art before. List only one cause on each line.	nter the mode of dying, such as cardiac o	r respiratory arrest,	,	Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition NECRO TIZIN	- PENCLEGITITIS			Onset and Death
	/Medical Examiner		Due to (or as a consequence of):				4 necks.
	_ xammer	<u>.</u>	Sequentially list conditions,	561773			(- ()
1	uted 1 Insit	Examiner	cause. Enter Underlying Cause (Disease or injury				
h,	cate be executed physician and the burial-transit	Exa	that initiated events c			-	
8760,	ate be nysicia ne bul	dical	d				
89	ng ph	Med	IF FEMALE:				
.O. Box	Physician: The law requires that the death certific this certificate has been signed by the attending praid director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 menths? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of del Month	ivery Day Year
ď.	s that ined b e deta	by Pt	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ıd	w requires that s been signed t should be deta	ed			1 □ Yes	2 7 No 3 □ Pi	obably 4 🗆 Unknown
of Vital Records,	sician: The law re certificate has be irector, page 2 sho	Completed			24a. Was an autopsy performed 1 ☐ Yes 2 ₩	d?// death?	atopsy findings available completion of cause of 2 □ No
/ita	clan: ertific ctor,	Be (25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		
of \	Physic rthis c	ဠ	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat			e 6 ☐Other (Spe	cify)
ū	ing P	ii o	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day, Year) 1 ☑ Natural 28b. Time	Work?	28d. Describe how i	injury occurred	
Sic	ttend death ttor:	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,	M 1 ☐Yes 2 ☐No	ORF Location (Stmo	et and Number or Ri	iral Route Number
Division	after a Direc	Certification:	4 Homicide determined building, etc. (Specify)	areet, factory, office	City or Town, S		stat Floate Wallibet,
	To the Hospital or Attending P within 24 hours atter death. To the Funeral Director: Aftert completely filled in by the funera	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de (Check only one) 1 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the caused at the time, date	se(s) and manner a e and place, and due	s stated. e to the cause(s)
	Vithin To the comp	Me	29b. Signature and title of certifier	29c. License number	29d.	. Date signed (Mont	h, Day, Year)
			10/10	D006537	4 1	May 25.	2009
	5		30. Name and address of person who completed cause of death (Item 23a) (Typ Aaron K4 65 noured 305 M	OSPITAL DRIVE	GLEN	U GURNIE	MD 2106/
	Sta Registr	_	31. Date filed (Month, Day, Year) JUN 0 2 2009 32. Fegistrar's Signature	Sarle			

DHMH 17 Rev 1/2001

09-04331 Mark Raines Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

rk Raines	1.	State of Maryland / Department Certificate		Reg. No.	09 175
Physicia	R	egistrar Decedent's Name (First, Middle,Last)		2. Date of Death 3.	Time of Death 0312 hrs
dical Exami	ner	Mark Jonathan Raines	4b. City, Town, or Location of Death	May 31, 2009 4c. County of Death	
ش	4	Facility Name (if not institution, give street and number) Good Samaritan Hospital	Baltimore		
Funeral		i. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs. Months Days Hours Min.	8. Date of Birth(MM/DD/YYYY) 9. Birthp April 6,1961 Foreign Country	lace (State or aryland
Director		Z 4 = 04 Z 5 0 1 1 1 1 1 1 1 1 1	Yrs.	April 0,1901 Coun	
, u		Jsual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo		1	0d. Inside City Limits
nd show a	5	MD	Baltimore	10g. Citizen of What Countr	
he Maryla or 28a-f	Director	10e. Street and Number 7218 Old Harford Road	10f. Zip Code 21234	USA	
15-0036 Hige within 72 hours after death with the Maryland Hige within 72 hours after death with the Maryland of other than "natural", or items 23a or 28a-f show any t, the Medical Examiner must be notified at once.	_ L	1 Never Married 2 Married Armed Forces? 1 Yes 2 XX No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.) 14. Race - America White, etc. whit	
s after ral", o	虿	Widowed 4 X Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Education (Specify only highest grade completed)	Yes 2 XXNo specify: edent's Usual Occupation (Give kind of v	work done 16b. Kind of Business/In	dustry
5-0036 led within 72 hours after tygiene. other than "natural", the Medical Examiner	Completed	durin	ng most of working life. DO NOT use reti Construction	Constructi Company	on
21215-0036 uld be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, Middle, Last) Raymond Raines, Jr	18.Mother's Name Betty.	e (First, Middle, Maiden Surname) lee Caplan	
h, MD 212' and 2 should be lealth and Mental tem 27 is marke traumatic event	To Be	19a Informant's Name/Relationship (Type, Print)		Rural Route Number, City or Town, State, sville, Maryland 210	87
Baltimore, MD 21215-0 permit. Pages I and 2 should be filed by Department of Health and Mental Hygi Important: If iten 27 is marked othin injury or other traumatic event, the 1		20a. Method of Disposition 20b. Place of Di	sposition (Name of cemetery,	Date 20c. Location - City or 1 Bel Air Ma	Town, State
Baltimore, permit. Pages I at Department of He Important: If ite		4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee	MATION (Belair) 6- 22. Name and Address of Facility EVANS FUNERAL CHA AND CREAMTION SER	PEL 8800 Harford VICES Parkville, Mar	Road yland21234
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not er	nter the mode of dying, such as cardiac	or respiratory arrest, shock, or heart	Approximate Interval Between Onset and
Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Heroin intoxicati			Death
aminer		or condition resulting in death) Due to (or as a consequence of):			
	Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
sd ssit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			
O, e be executed ysician and burial - transit	edical	X UNPENDED AMENDED 23a,PII,27,2	8a-f,perME, g892 6	5/12/09 TT	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician To the Funeral Little or As directors are 2 should be detached for use as the burst	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregr	23d. Date of deliver mancy Month I	y Day Year
Box e death the atte	hysi	1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?
, P.O. B ries that the d signed by the		Atherosclerotic cardiovascular d		1 Yes 2 No 3 Pro	
Division of Vital Records, Islands after death. Is after death. In a Director: After this certificate has been signed in the change of the control of the co	Completed by	None 2 and 2		autopsy prior to performed? death?	utopsy findings available completion of cause of
Reco The law icate has	E E		26.Place of Death (Chec	1 Yes 2 No 1 Y	es 2 No
ital Rec ician: The s certificate	B	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outp	I Othor:	sing Home 5 Residence 6 Other	er:
n of Vi ling Phys After this	ĕ ⊢	1 V Yes 2 No	me of Injury 28c. Injury at Work?	28d. Describe how injury occurred unk	
ttendir death.	atio	Pending Fd 5/31/09 Fd 2 Accident Accident Accident Accident Accident Fd 5/31/09 Fd 2	2:18 am 1 Yes 2 21 No	28f. Location (Street and Number of Four Town, State) / 218 016	ural Route Number, City
Divisior To the Hospital or Attentwithin 24 hours after death To the Funerial Director:	edical Certification:	Suicide determined (Specify)	vacant house	Baltimore, MD	
e Hospi 124 hou		29a Certifier . The state of the heat of my knowledge death	n occurred at the time, date and place, a restigation, in my opinion, death occurre	and due to the cause(s) and manner as sta ed at the time, date and place, and due to	ated. the cause(s)
To the vithin To the	Medical	29b. Signature and title of certifier	29c. License number	29d. Date signed (M	onth, Day, Year)
	12	/ his, no	O.C.M.E.	May 31, 2009	
· at	A	30. Name and address of person who completed cause of death (Item 23a)	Ot P-111 MD 04004		
300	5	Ling Li, MD Assistant Medical Examiner 111 Penn	Street, Baltimore, MD 21201		
Dan	Stat	31. Date filed (Moeth, Day, Year) 32. Registrar's Signature	when the same of t		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year 2:45 AM Kocker ames May 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Genesis Brightwood Baltimore Baltimore County 8. Date of Birth (Month, Day, Year May 29 1913 If Under 1 Year | If Under 24 Hrs. Social Security Numbe 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 213 10 8237 1 □xM 2 □ F 96 Months Days Hours Baltimore, Maryland Yrs Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Baltimore Baltimore County 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3704 Parkhurst Way 21236 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 [] Yes 2 [] 100 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Tyes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2 🗷 XIo Specify. Specify: 3XXWidowed 4 ☐ Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Machine Shop Worker Bethlehem Steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Albert Rocker Tina Yanda 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles J Rocker (Son) 23 Arlen Road Apt. E Baltimore, Maryland 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Parkwood Cemetery June 3 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service, Licensee 22 Name and Address of Facility
Lassahn Funeral Home Inc. 7401 Belair Road Baltimore, Maryland 21236 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Day disease or condition resulting in death) Prostute oncer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Dother (specify) 1 ☐ Yes 2 ☐ No 9 Unknown

Physician /Medical Examiner Examiner or Attending Physician: The law requires that the death certificate be executed

Physician

/Medical

Examiner

10a. State

Director

Funeral

Be Completed by

ဂ္

Funeral

Director

id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

s 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other than "other traumatic event, Item Men

permit. Pages 1 and 2 Department of Health Important: If item 27 any Injury or other tr once.

Pages 1

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

the burial-transi physician use as for the as been signed by the should be detached After this certificate has page 2 funeral director, s after de... ral Director: After within 24 hours after dea To the Funeral Director completely filled in by the

Physician/Medical

Completed by

Be

Certification: To

Medical

Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in	Part I. 23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 No 3 □ Probably 4 □ Unknow
		24a. Was an autopsy prior to completion of cause or performed? 1 □ Yes 2 No 1 □ Yes 2 No
25. Was case referred to medical	26	. Place of Death (Check only one)
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other:	Nursing Home 5 Residence 6 Other (Specify)
27. Manner of Death ↑ Natural 5 ☐ Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? n	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)
	nysiclan: To the best of my knowledge, death occurred at the time, on the basis of examination and/or investigation, in my opinion	date and place, and due to the cause(s) and manner as stated. on, death occurred at the time, date and place, and due to the cause(s)

Registrar

31. Date filed (Month, Day, State

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

2009

30. Name and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 30 **Physician** 2009 4:33 P M ROBERT RITSER /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 6503 PARK HEIGHTS AVE., #LK BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 01/22/1942 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) Funeral Months Hours Davs HUNGARY 497-44-4409 67 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 1 X Yes 2 □ No "natural", or items 23a or 28a-f shidical Examiner must be notified Director MD N/A BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 6503 PARK HEIGHTS AVE., #LK 21215 Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 MYes 2 ☐ If Yes, Give Year or Dates: Z No KOREA 1 Never Married 2 Married 1 □Yes 2 No Specify: WHITE Specify ģ ARMY 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d other than "natu event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, The Monee. SALES REPRESENTATIVE GARMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FRANK RITSER UNKNOWN BLANKA ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EVA SCHWERER / COUSIN 7954 STARBURST DRIVE, BALTIMORE, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State HILLTOP SERVICE CORP 06/01/2009 TOWSON, MD 4 □ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signatur SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician BD disease or condition resulting in death) /Medical ue to (or as a consequence of) Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events 28100 Due to (or as a consequence of) Examine burial-tra that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>\$</u> 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be irector, page 2 s autopsy performe 1 □Yes 2 ☑No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 3 | N 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

2

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

State Registrar

Medical

31. Date filed (Month, Day,

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person

32. Registrar's Signature

eted cause of death (Item 23a) (Type, Print)

and manner stated.

1 Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 3:45 PM RAPOPORT KIM 2009 Mai 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death RANDALLSTOWN BALTIMORE HOSPITAL SEASONS HOSPICE @ NORTHWEST If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/28/1927 Birthplace (State or Foreign Country) 6. Sex 1 X M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday, Hours Months Days UKRAINE 212-37-9525 82 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 X Yes 2 No N/A BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 3615 FORDS LANE, #215 21215 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ∭No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 X No WHITE Specify: Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) ENGINEERING **PROFESSOR** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) RAPOPORT SHLAEN FAYGA BENYUMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3615 FORDS LANE, # 215 , BALTIMORE, MD 21215 YEVGINIA GRINBERG / WIFE 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of ZI Carrier Nordina RVA (AM) place) 1 Burial 2 Cremation 3 Removal from State NACHMAN CONGREGATION | 05/31/2009 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Sign, ture of Funeral Serv 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lim. Immediate Cause (Final disease or condition resulting in death) Stage Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 No 1 ☐Yes 2 🖾 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother Specify NS HOSPICE

Physician /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

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Completed

Be

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Funeral

Director

28a-f show

ō death with

23a

items 2

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"natural"

Department of Health and Mental Hygiene important: If item 27 Is marked other than any injury or other traumatic event, the Maone.

be filed within 72 hours after

Pages 1 and 2 should

altimore, Maryland 21215-0036

traumatic event, the Medical Examiner must be notified at

and burial-tran attending physician for use as the burial signed by the a certificate has been s rector, page 2 should director, this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral or

Division of Vital Records, P.O. Box 68760,

Examiner Physician/Medical à Completed Be Certification: To

IF FEMALE

1 Yes

29a. Certifier

2 No 27. Manner of Death 5 Pending investigation 2 Accident 3 Suicide 4 Homicide

6 ☐ Could not be

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Medical

2835 32. Registrar's Signature (Month, Day, Year) JUN 0 2 2009

State Registrar

within 2.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 🛛 🗍 🦠 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death Month Day 2009 Year **Physician** 25 May 07:30a M Henry Rinehart /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Hours Days 1 X M 2 □ F Months 1929 WV 80 Feb. 4, 232-44-1078 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10h County 1 □Yes 2 No Director Prince Georges Upper Marlboro 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 17310 Brookmeadow Lane 20772 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑Yes 2 ☐ No 16 Fee, Give 1956— 14. Race - American Indian, Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: Specify: ģ 3 Widowed 4 Divorced 1976 Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Wonder Bread Laborer 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jennie Dubin Jesse Rinehart ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
17310 Brookmeadow Lane
Upper Marlboro, MD. 20772 19a. Informant's Name/Relationship (Type. Print) Sallie Rinehart-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 7-2-2009 Arlington National Arlington, VA. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Marshall's Funeral Home of Maryland 21. Signature of Fundal Service Licens 4308 Suitland Rd. Suitland, MD. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 0 disease or condition resulting in death) Due to (or as a consequence of): Cardiovascular discare Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner 12 ath 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred t tural 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

attending physician and for use as the burial-tran Box 68760. signed I

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician/Medical

Completed cate has l page 2 s certificate Be Certification: To

To the Hospital or Attending Physiclan: The law requires that the death certificate be executed P.0. Division of Vital Records, ithin 24 hours after death.

the Funeral Director: A simpletely filled in by the fu

State

and manner stated

29c. License number 00060100

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

ALTMED

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAHMINA Silversmp

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

(Check only one)

Medical

completely

2

32. Pegistrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Department	artment of Health and N rtificate of Death	, ,	ene 2009	17601
1			Decedent's Name (First, Middle, Last)		2. Date of Death	1	3. Time of Death
	Physici /Medic		Mary Josephine Smith		Month May	30 2009	6:15 pm ^M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
age of the			Harborside Harford Gardens 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Baltimore If Under 1 Year If Under 24 Hrs.	8 Date of Birth	N/A	ace (State or Foreign
ı	Funeral Director		217-34-4609 1 M 2 M F 104 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, March 23,	Year) County , 1905 Mary	trv)
	land 5w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation		10	d. Inside City Limits
	Mary a-f she	ctor	Maryland N/A Baltimo	re			XXYes 2 □ No
	or 28	Dire	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Count	ry?
	s 23a	eral	3929 Lyndale Avenue	21213		Jnited State	
5-0036	urs after de al", or item	by Funeral Directo	Armed Forces? 1 Never Married 2 Married 1 Yes 2 Mo If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 □Yes 🌠 No Specify:	ecity Yes or No- Rican, etc.)	14. Race - America Black, White, e Specify: Whit	tc.
21215-0	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, if a fredict Exarting trivial be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary(Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing	6b. Kind of Business/Ind	•
	filed v Hygie other i	င်	8 Book 17. Father's Name (First, Middle, Last)	Keeper 18. Mother's Nam	e (First, Middle, Mi	Spice Compar aiden Surname)	ıy
ılan	should be filed withir nd Mental Hygiene. marked other than matic event, In Ell	To B		Mary	Hrachove	•	
Maryland	S S S	Ţ		ng Address (Street and Number or Rui	ral Route Number,	City or Town, State, Zip	Code)
	1 and 2 Health em 27		Mary F. Smith/Daughter 3929 20a. Method of Disposition 20b. Place of Dispo	Lyndale Avenue	Baltimo	ore, Marylar	nd 21213
Š E	Pages nent of int: If its iry or o			sition (Name of natory or other place) ill Cemetery 6/3/0		len Burnie,	,
Baltimore,	permit. Pages Department of Important: If ii any injury or once.	H	21. Signature of Funeral Service Licensee	2. Name and Address of FacilitySch	imunek Fu	ineral Home,	Inc.
m	8 9 E 8 8	0_1		05 Belair Road Ba			21236
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	er the mode of dying, such as cardiac Chodo my yzath Heart Foulu		st,	Approximate Interval Between Onset and Death
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ecords, P.	requires that the peen signed by th hould be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions.	nderlying cause given in Part I.		acco use contribute to the	e cause of death? ably 4 1 Unknown
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V 115	Physician: r this certificaral director, p	Be	25. Was case referred to medical examiner? 1 Types 2 Types Hospital:	000	h (Check only one)		
	g Phys er this eral dii	٦: 10	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at	me 5 Residen	nce 6 Other (Specify)
0	Attending or death. ector: After by the funer	atio	1 Matural 5 ☐ Pending (Month, Day, Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		,	
DIVISION	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)		City or Town,	,	
	To the Hospital or within 24 hours afte To the Funeral Dir.	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deatly and manner stated.	vestigation, in my opinion, death occur	red at the time, dat	te and place, and due to	the cause(s)
	Vit Cor	2	29b. Signature and title of certifier	29c. License number D3iy64	29	d. Date signed (Month, E	Jay, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type.	Print)		3(110)	
	Stat	te	Stuaris A. Has Hanna, 820 N. Fut. 31. Date filed (Month, Day, Year) JUN 0 2 2009 Registrar's Signature	AW ST Ente 3	08 BAL	TIMOREM	0 2(20)
	Registra	_	JUN 0 2 2009 Kenne B. Agai	1500			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 2 1 26 per verb., g892,06/02/09dhb Certificate of Death Reg. No. State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician **Anne Morris Short** May 26, 2009 7:30 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Columbia Howard Harmony Hall Assisted Living Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 DE Months Days Min Yrs Director MD Usual Residence of Decedent Jul 5, 1929 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinating the numbed at 1 ☐ Yes 2 No Director Catonsville **Baltimore** MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21228 1914 Rollingwood Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: <u>გ</u> 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Unt. Own Home Homemaker_ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Sue Barger Hanson Thomas Morris Johnson Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13370 Brighton Dam Rd. Clarksville, MD 21029 Steve Short Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Di≰pgsition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 28, 2009 Glen Burnie, MD Atlantic crematory LLC 22. Name an Address of Facility 21. Signal, re of Furieral Service Licensee 3871 OLD COLUMBIN PILE * MO1793 Sinch Funeral Home, PM CLUGTT CITY, MO 21043 23a. Part 1. Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NON SMALL CELL LUNG CANES **Physician** 6monts /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) sician and burial-trans Due to (or as a consequence of): P.O. Box 68760 attending physician for use as the burial Physician/Medical IF FEMALE signed by the attending be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Assisted Hospital: Other: 4 Nursing Home - Thesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Living 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 To the Hospital or Attending within 24 hours after death. To the Funeral Director; After 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier, 016354 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATONAVE BALTIMORE MD ST AGNES 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

JUN 02

09-04241 Milton Stepney

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 17606

. ,		1- For State Certific	ate of Death	Reg.	No.	
Physicia edical Exami	an/	1. Decedent's Name (First, Middle, Last) With Stephey		2. Date of Death Month D May 28, 200	ay Year 9	3. Time of Death 0328 hrs
		4a. Facility Name (if not institution, give street and number) University Hospital	4b. City, Town, or Location of Death Baltimore	h	4c. County of Deat	1/A
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bir 220-86-4505 1 M 2 F 3	thday) If Under 1 Year If Under 24Hr Months Days Hours Min	· ·	Forei	rthplace (State or gn puntry) Maryland
uth with the Maryland tems 23a or 28a-f show any st be notified at once.	Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town 10c. Street and Number 10c. Street and Number 11c. Marital Status 11. Never Married 12. Was Decedent Ever in U.S. Armed Forces?	n or Location Battimore 10f. Zip Code 21217 13. Was Decedent of Hispanic Origin? (Sif Yes, specify Cuban, Mexican, Puert	Specify Yes or No-	Citizen of What Cou	10d. Inside City Limits 1 Yes 2 No Intry? rican Indian, Black,
15-0036 filed within 72 hours after death with the Maryland I Hygiewei I Agother than "natural", or items 23a or 28a-fehe i, the Medical Examiner must be notified at once	Completed by Fur	Widowed 4 Divorced 1 Yes 2 No 1 N	1 Yes 2 No specify: Decedent's Usual Occupation (Give kind of during most of working life, DO NOT use re	tired)	Specify: Blo 6b. Kind of Business City of	nek //ndustry Ballimore
AD 21215-0036 2 should be filed within 77 h and Mental Hygiene. 27 is marked other than imatic event, the Medical	To Be Co	17. Father's Name (First, Middle, Last) Victor Stepney 19a. Informant's Name/Relationship (Type, Print) 19a. McNeil Sider	9b. Mailing Address (Street and Number or	ne (First, Middle, Ma	er	e, Zip Code) 2/2/7
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within permit. In the Mealth and should be filed within Important: If item 27 is marked other it injury or other traumatic event, the Med		20a, Method of Disposition 20b. Place	of Disposition (Name of cemetery, atory or other place) 22. Name and Address of Facility fig. 3512 Frederick	Date Hog Kerture	Baltimore Eraf Hone	e Marylerd F.A. 21229
Physician M. dical xaminer		23a. Part I. Enter the disease, or complications that caused the death. Do refailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	not enter the mode of dying, such as cardiac	or respiratory arres	t, shock, or heart	proximate Interval etween Onset and Death
cuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate course. Exter Underlying Course. (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				
ox 68760, ath certificate be exe attending physician a	ysician/Medical	UNPENDED AMENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown AMENDED 23c. If yes, outcome of pregnance 1 Live birth 4 Pregnant at time of death 9 Unknown	y 2 Fetal death 3 Ectopic preg 5 Other (Specify)	nancy	23d. Date of delive	ery Day Year
Records, P.O. Bot: The law requires that the deficate has been signed by the it, page 2 should be detached fi	Completed by Phy	Part II. Other significant conditions contributing to death but not resulti	ng in the underlying cause given in Part I.	1 Yes 24a. Was ar autops	2 No 3 Propriet	to the cause of death? robably 4 Unknown autopsy findings available ocompletion of cause of
tal Recc clan: The la certificate ha		07. W	26.Place of Death (Chec	perform 1 Yes 2		
of Vital ng Physician After this certi	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 ✓ Inpatient 2 ER/	Outpatient 3 DOA Other Num	sing Home 5 F	tesidence 6 Ott	ner:
ion of tending Pl eath or: After the funeral	ıtion: T	1 Natural 5 Pending (Month, Day Year) 02	28c. Injury at Work? 42 hrs 2 ✓ No	28d. Describe he Subject shot	ow injury occurred	
Division pital or Attendiours after death eral Director: Affiled in by the fi	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Sidewalk	farm, street, factory, office building, etc.		reet and Number or ate) ombard Street, Ba	Rural Route Number, City altimore, MD
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, done) Medical Examiner: On the basis of examination and/or and manner stated.	eath occurred at the time, date and place, a rinvestigation, in my opinion, death occurre	nd due to the cause d at the time, date a	(s) and manner as s nd place, and due to	tated. the cause(s)
Fe wi	Me	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (I May 28, 2009	Month, Day, Year)
5 V		30. Name and address of person who completed cause of death (Item 23a Ana Rubio MD. Assistant Medical Examiner 111	I : Penn Street, Baltimore, MD 212	01	_	
S Regis	tate trar		bares			

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2 B Catherine Santos **Physician** 0630 AM 2009 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** July 21, 556-98-1455 57 New Jersey Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c. City, Town or Location show must be notified at 1 X Yes 2 □ No Director MD N/A Baltimore 28a-f 10g. Citizen of What Country 10e. Street and Number 10f. Zip-Code 6 23a 21231 623 Durham Street USA Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian ıral", or iten I Examiner r Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2X No Specify: White ò 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done di life. DO NOT use retired) during most of working Elementary/Secondary (0-12) al Hygiene. College (1-4 or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be marked o Ardoyne of Health and Menta fitem 27 is marked rother traumatic ev Santos Catherine Joaquim မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Patricia M. Santos, sister 2607 Acadia Street Durham, NC Department of Healt Important: If item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 05/30/09 Baltimore, MD 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Squamous cell disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Unioning Cause (Disease or injury that initiated events Due to (or as a consequence of): Attending Physician: The law requires that the death certificate be executed as the burial-transit resulting in death) Last Due to (or as a consequence of) physician Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Month Vear Pregnant at time of death 5 Other (specify) ed by the att 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 XInpatient Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\subseteq \left\) Residence 2 No 1 🗌 Yes 2 ☐ ER/Outpatient 3 ☐ DOA 6 ☐ Other (Specify) ည after death. Director: After this filled in by the funeral Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1X Natural 5 Pending investigation Injury 1 🗌 Yes ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ь within 24 hours a

To the Funeral C

Completely filled the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier MD 28,2009 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wagi 600 North Wolfe St, Baltimore, MD, 21287 ikohan Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 26,^{Day}009 Month MAY Physician 5:00P HELEN VIRGINIA STINE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CHARLES GENESIS LA PLATA CENTER LA PLATA 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth

(Month, Day, Year)

1-12-1921 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 □ M 2 😾 F Yrs 213-40-5394 88 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location show or items 23a or 28a-f shore interpretations of the contract of the continued at the continued at X Yes 2 No MD. LA PLATA CHARLES Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number Pages 1 and 2 should be filed within 72 hours after death with 20646 S.A. MAGNOLIA DRIVE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 □Yes 2 No Specify. SpecifyWHITE th and Mental Hygiene.
7 is marked other than "natural", or traumatic event, the Medical Exp. þ 3√2 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be THOMAS HARDESTY LYDIA DAVIS ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is u
any Injury or other trausonce. RAYMOND A. STINE, JR. - SON 36725 DOG PARK LN. MECHANICSVILLE, MD. 20659 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State HOLY GHOST CEMETERY 6-1-09 ISSUE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses M00479 RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MD. 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DSCLEROSIS DIAMEIND Physician yeurs /Medical Due to (or as a consequence of): Examiner RIMI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician; The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician for use as the burlal Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) ate has been signed by page 2 should be detack 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 24 hor To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signatur and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

address of person

32. Registrar's Signature

who completed cause of death (Item 23a) (Type

JN 0 2 2009 Januar D.

2060

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2009 8:30A June 01 Veloies Smith /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Center Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 T G 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 □ F NC Director 70 214-78-1220 03-16-39 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Evandous is ust be multiped at 1 Yes 2 □ No Director Baltimore MD NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21218 302 East 20th Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2X No Specify Specify: Black ۵ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Unemployed Unemployed NA None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WallACE Beatrice Wallace ဥ Charles 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other trau once. 8217 Stewarton Court Severn, MD 21144 Baha Wali - Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Zion Cemetery 06-05-09 Lansdowne, MD Mt. 22. Name and Address of Facility Wylie Funeral Homes P.A. 21. Signature of Funeral Service License MD21217 Street Baltimore, 638 N. Gilmor Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician TA 18an disease or condition resulting in death) /Medical Examiner Saperitially not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed led by the attending physician and detached for use as the burial-tran burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 🗌 No 3 Probably 4 ☐ Unknown Completed been s page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy performed2 Physician: The certificate 1 Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Hospital or Attending Pl 24 hours after death. Funeral Director: After the 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number City or Town, State) filled in by 4 🗌 Homicide 1 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only To the within 2. and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Chales St. Balto and 21 704 GONC 0 31. Date filed (Month, Day, 32. Registra State JUN 0 2 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 3:14P M MAY Michael David Saffer 39 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Joseph Medical Center Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 XM 2 F 212-22-0820 Aug. 6, 1925 Maryland 83 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County r than "natural", or items 23a or 28a-f show the Medical Evaminer must be notified at 1 ☐ Yes 2 No Director Baltimore MID Baltimore 10g. Citizen of What Country? 10f. Zip Code 4300 Cardwell Avenue #301 21236 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1√2 Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married White Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Saffer Plumbing and Mental Hygiene. Is marked other than Plumber 12 18. Mother's Name (First, Middle, Maiden Surname)
Marie Saffer 17. Father's Name (First, Middle, Last) Be Mental , Pages 1 and 2 should be tment of Health and Ments tant: If Item 27 Is marked jury or other traumatic ev John Ball ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21234 Perry Woods Court-Parkville, Maryland David Saffer-son altimore. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place).

Gardens Of Faith Date 20a. Method of Disposition 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removal from State June 3,2009 Rosedale, Maryland Department of important: If any injury or 4 Donation 5 Dother (Specify) Cemetery 22. Name and Address of Facility
EVANS FUNERAL CHAPEL 21. Signature of Funeral Service Licensee 8800 Harford Road Parkville, Maryland 21234 molis AND CREMATION SERVICES 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ISCHEMIC CARDIOMYOPATHY disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine executed and burial-trar Due to (or as a consequence of) Box 68760, physician pe Physician/Medical certificate use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy The law requires that the death Month Day Year for in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 0 been signed by the should be detached 1 ☐ Yes 2 ☐ No. 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an FRACTURE autopsy performed? has page 2 this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifics completely filled in by the funeral director, for 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred patricult was 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: Division Injury 5 Pending investigation 1 Natural
2 Accident May 17, 2009 Unknown 1 ☐ Yes 2 No his balance and Fell. 6 ☐ Could not be 28f. Location (Street and Number or Fural Route Number City or Town, State) 2300 billion by the level 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 5 to 110 Maris Nare determined 4 ☐ Homicide home, Patients bathroom TIMONIUM, Maryand 21073 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

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ZAMI OSLER DRIVE TOWSON MARYLAND

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 6:00 AM 104 28, 2009 Spence Lenora /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Union Memorial Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 💢 F Yrs 54 Director MD 06 214-62-9208 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director MD NA Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with Hygiene. U.S.A. 21213 1428 North Luzerne Ave Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces' Never Married 2☐ Married 1 □Yes 2 XNo Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. ģ Black 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) s 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Mercy Hospital Nursing Aide 10th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Carolyn Denmark Jerome Spence 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Md 21213 1428 North Luzerne Ave, Alexander Little-Friend permit. Pages 1 a
Department of He
Important: If iten
any injury or oth 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) King Memorial Park 6/3/09 Woodlawn, Md 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H West 4300 Wabash ave, Baltimore, Md Approximate Interval Between Onset and Death 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final One Week **Physician** Preumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Expresses or injury that initiated events resulting in death) Last iner Due to (or as a consequence of): law requires that the death certificate be executed Exam sician and burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown icate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 □Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital director, 25. Was case referred to medical 26. Place of Death (Check onl one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month.

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1)orat

Year)

29c. License number

AT 2438946-

Memorial Hospital,

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - For State Registrar	otato or marytan	Cei	rtificate of Dea	th	orital Try	Reg. No. 2	009	176	
Physici	ian	1. Decedent's Name (First, Middle, La	ast)		Smith Sr.		2. Date of De Month 05	Day	Year 2009	3. Time of De 12:10	
/Medic		Thomas 4a. Facility Name (If not institution, given	re street and number)		4b. City, Town, or Locat	ion of Death	0.5		ty of Death	12.10	νρ•
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		Future Care Nu 5. Social Security Number 6.5	Sex 7. Age (In yrs. I	last hirthday)		nder 24 Hrs.	8. Date of Bir	th	9. Birthr	place (State or F	oreign
Funeral Director			1½ M 2□F 80	Yrs.	Months Days Hou	urs Min.	(Month, Da	y, Year) 6 28	Cour	PA	
and and t		10a. State 10b. County	10c. City	y, Town or Lo	cation				1	0d. Inside City L	Limits
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the N 28a- notifi	Director	10e. Street and Number	•		10f. Zip Code			10g. Citizen o	of What Cour	ntry?	
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eath	era	11. Marital Status	12. Was Decedent Ever in U.S	S. 13. V			ecify Yes or No	- 14. F	ace - Americ	can Indian,	
ING Z I Z I 3-UU30 be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of Hispani If Yes, specify Cuban, Me 1 □Yes 2 ☑ No <i>Spe</i>	xican, Puerto	Rican, etc.)	Spe	lack, White,		
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Iryland Z hould be filed and Mental Hygi marked other matic event, I	Be C	17. Father's Name (First, Middle, Last					(First, Middle	Maiden Surn	ame)		
	To B	Joel Smith			Ed	ith T	homas				
aryland should be f and Mental I s marked or sumatic eve	F	19a. Informant's Name/Relationship	(Type. Print)	19b. Mailir	ng Address (Street and N			er, City or Tov	vn, State, Zip	Code)	
Maryland d 2 should be file th and Mental Hy z is marked oth traumatic event		Kathleen Smith		1	5 Dukeland						16
9 5 5 E		20a. Method of Disposition			sition (Name of natory or other place)		ate	20c. Locatio		_	
Baltimore, permit. Pages 1 ar Department of Hea Important: If item; any injury or other		t Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Contro	fy)	Crest!	lawn	6/4/	09	Marri	otts	ville,	Md
Depariment and in the control of the		21. Signature of Funeral Service Lice	March	_ Ma	Name and Address of E arch F/H W 300 Wabash	est Ave,	Balti	more,	Md,	21215	
Physician /Medical Examiner		23a. Part1. Ehter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	pplications that caused the death one cause on each line. a	10 (BSTRLICTIVE	10		9	1se A	Approximate Interval Betwe Onset and Dea	en ath
ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	bue to (or as a consequ	uence of):							
DB/DU, rtificate be executed ng physician and as the burial-transit	I Examiner	that initiated events resulting in death) Last	c Due to (or as a consequ	uence of):							
58 / 50, rtificate be example of the construction of the construction as the burial	Aedical		d								
BOX eath ce attendi for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3b. Was decedent pregnant in the past 12 months? 1						Date of deliv Month	rery Day Yea	ar
COLdS, P.O. w requires that the d been signed by the should be detached	by	Part II. Other significant conditions	contributing to death but not resu	ulting in the u	nderlying cause given in F	Part I.		tobacco use c Yes 2 □ No		the cause of dea	
Kecords, he law requires t e has been signe ge 2 should be c	Completed						24a. Was auto perfo	psy ormed?	prior to co death?	opsy findings avo	ailable use of
		25. Was case referred to medical			00.1	Diseased Death	1 □Yes ∩ (Check only	2.⊿No	1 □Yes	21 No	
Or VICE Physician: this certific al director,	Be	examiner?	Hospital:	EB/Outpotion	Other		me 5 ☐ Res		Othor (Casa	:6.)	
Phys rthis ral dir	l:	27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	28b. Time o			me 5 ∟ Res 28d. Describe			my)	
ding I h. After funer	ţi	1 Natural 5 ☐ Pending	(Month, Day, Year)	Injury	f 28c. Injury at Work? M 1 □ Yes						
INVISION OF VITA I or Attending Physician: after death. Director: After this certific d in by the funeral director,	Certification:	2 Accident Investigation 3 Suicide 6 Could not to 4 Homicide determined	De 290 Place of Injury At he	l ome, farm, str by)			28f. Location (City or To	Street and Nu wn, State)	mber or Rur	al Route Numbe	э <i>г</i> ,
To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	edical Ce		hysician: To the best of my kno miner: On the basis of examina								
thin 2 the mple	Med	29b. Signature and title of certifier	and manner stated.		29c. License num	ber		29d. Date sig	ned (Month	Day, Year)	
7 wit		Januare January	Lachani	ni				Α .			
_									- ,		
		30. Name and address of person who	o completed cause of death (Item	m 23a) (Type,	Dd850 Print) 835 Smith	4 AVE	BA	LTO M	دالى لا	r-P	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 28a 28c, per Phys, G892, 672/09, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 0 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death MAMonth 28 2009 3:19P BESSYE SILVER 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE BALTIMORE 3828 BYFIELD ROAD 8. Date of Birth JUM 1928 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 214-24-8312 Months Days Hours Min MARYWAND 1 □ M 2**X X**F 80 Yrs. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2XXNo BALTIMORE BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21207 3828 BYFIELD ROAD 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2No Specify: Specify: WHITE 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CUSTOMER SERVICE REP. RETAIL 18. Mother's Name (First, Middle, Maiden Surname)
ALICE
Ü 17. Father's Name (First, Middle, Last)
HERMAN ÚNKNOWN **GINSBURG** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8007 UPPERFIELD COURT OWINGS MILLS, MD 21117 MARK SILVER/SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition RUDOMER VEREIN 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 6/1/2009 ROSEDALE, MD 5 ☐ Other (Specify) 4 Donation 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that closed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Advanced AlZheimer lo years Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Molestero 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? 1 □ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Tesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

/Medical Examiner Hospital or Atteriding Physician: The law requires that the death certificate be executed and Division of Vital Records, P.O. Box 68760, After this death. n 24 hours ar er d e Funeral Direc within 24

Physician

/Medical

MD

Director

Funeral

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Medical Certification: To

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Everinet must be notified at once.

Physician

Baltimore, Maryland 21215-0036

burial-tran attending physician for use as the buria Director

State

Registrar

ur

29c. License number

29d. Date signed (Month, Day, Year)

Owings Mills, MD 21117

-IMD

D00677

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Cressroads Dr.

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

32. Registrar's Signature

amend item 29d per doc 9892 6-2-09 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Turner 6:301 M Todd 200 MA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 3928 Addison Urbana rederick Woods If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 6. Sex Social Security Number **Funeral** Days Hours 1 M 2 □ F WASHINGTON DO 214-80-039 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the was foal Even, in result by notfiled at once. 1 ZYes 2 □ No FREDERICK URBANA MO Director 10g. Citizen of What Country? 10e. Street and Number Addison USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1∐Yes 2∏ÎNo Specify: WHITE ş 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRIAD Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION CONSTRUCTION 12 771 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Barbara A. JOHN HARDY Urner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Woods TURNER e/1559 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) my 28, 2009 Smithsburg Md. 22. Name and Address of Facility GARY L. ROLLINS FUN. Hom & 21. Signature of Funeral Service Licenses FREDERICA MO 21701 SOUTH SI 110 WOI Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 53 quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 □Yes 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? certificate 1 ☐Yes 2 ☐No after death.

Director: After this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by determined 4 🗌 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2009 28 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5454 Wixons MD egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Funeral Director 28a-f show

Physician /Medical Examiner

3altimore, Maryland 21215-0036

Box 68760. P.0. Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month MAY Day 1 **Physician** ¥981719 07:55A May Thompson Muriel /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death Examiner Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, O 5 12) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🕶 F Yrs 213-60-4122 73 Jamaica Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location init. Pages 1 and 2 should be filed within 72 hours after death with the Maryla artment of Health and Mental Hygiene. ortant: If them 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Madical Examinar must be notified at Y∑Yes 2 No Director Baltimore MD NA 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code 21239 U.S.A. 1675 Burnwood Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify ģ 3 ₩ Widowed 4 Divorced Black Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Home 12th grade Nurse Assistance na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Aaron Colsock Hilda Brooks ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1675 Burnwood Road, Baltime, Md 21239 Jennifer Walker-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or once. Woodlawn 6/13/09 Woodlawn 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md dmor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final METASTATIC GASTRIC CANCER disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To Inpatient 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natura! Injury 1 ☐ Yes 2 ☐ No 2 Accident **Director:** 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21204 POH LIM. M. D. 7601 OSLER DRIVE TOWOSN, MARYLAND BOON 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

A. gark DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav **Physician** 09 Ellen /Medical Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner Baltimore , I Kens Date of Birth (Month, Day, 12-24 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Hours 1□ M 2XF 70 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or items 23a or 28a-f show, other traumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number Funeral 12. Was Decedent Ever in U.S Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2**Y** No Specify. ģ Black permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", any hjury or other traumatic event, Ire Mudical Exagnee. 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) pring Grove Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be or Rural Route Number, Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Interstitual Dulm onary 54-ears **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to for as a consequence off attending physician and for use as the burial-transit Exami Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 No signed by the a P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen (24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ ₩6 24a. Was an autopsy has performed within 24 hours after death.

To the Funeral Director: After this certificate 2 No 1 □ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death or Attending 5 Pending investigation 1 Natural 1 🗆 Yes 2 🗌 No 2 Accident the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

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State

31. Date filed (Month, Day, Year)

JUN 0 2 2009

Belie due Ave

person who completed cause of death (Item 23a) (Type, Print)

2435

Registrar's Signature

W

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 28 2009 **Physician** 11:50 P ^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City Town, or Location of Death Examiner Lorien Mays Chapel Lutherville Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 □ F Months Days Hours Min. 214 20 7424 Director 97 February 3 1912 Wilkes Barre, PA Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, if w Medical Examiner must be notified at Director 1 ☐Yes 2 ☐ No Baltimore Maryland Hvdes 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5112 Elder Road Funeral LISA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 21215-0036 Completed by If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) N/A Production Planning Glenn L Martin Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Is marked ot should be Morgan Jones Ann Elizabeth Gormlev ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Elizabeth Elder 5112 Elder Road Hydes, Maryland 21082 injury or other Department of Heal Important: If item 2 any injury or other once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 D Burial 2 Cremation 3 Removal from State Moreland Memorial Park June 1 2009 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Union, in Cause (Disease or injury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician a the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal deat in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 : autopsy perform After this certificate 1 Yes 2 No 1 □Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 Z No Hospital: Other: 4 Nursing Home 1 ☐ Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 ☐ Accident 5 ☐ Pending investigation eral Director: A 1 ☐Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 J. MEU ZER TEXAS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 2 2009 Registrar

09-04306 Mathew White Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2009 17619

	Day Year CAAF box
dedical Examiner Mathew C. White May 30, 2	2009 real 0445 hrs
4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	4c. County of Death
Peninsula Regional Medical Center Salisbury	Worcester
1 And the second of the second	irth(MM/DD/YYYY) 9. Birthplace (State or Foreign
Funeral S. Social Security Number C. Sex Min. Months Days Hours Min.	Country)
Director 212-06-0703 1X 2 F 41 Yrs. Months Days Hours Mill. 04/0	1/1968 Baltimore, MD
Usual Residence of Decedent	10d. Inside City Limits
10a. State 10b. County 10c. City, Town or Location	
문호병 MD Baltimore Baltimore	1 Yes 2 X No
MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
10e. Street and Number 10e. Street and Number 10f. Zip Code 21244	U.S.A.
11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or N	
11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 X Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No specify:	White, etc.
1 Yes 2 X No 1 Yes 2 X No 1 Yes 2 X No specify:	_{Specify:} White
or Dates: 15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Usual Occupation (Give kind of work done	16b. Kind of Business/Industry
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9 E TEST TO Master HVAC Technician	Defense
Master HVAC Technician 12 Master HVAC Technician 18. Mother's Name (First, Middle, Last) 17. Father's Name (First, Middle, Last)	, Maiden Surname)
رِي الله الله الله الله الله الله الله الل	
Master HVAC Technician 12 Master HVAC Technician 13. Mother's Name (First, Middle, Last) Harry White Joan Keefer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailling Address (Street and Number or Rural Route No. 19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailling Address (Street and Number or Rural Route No. 19a. Informant's Name/Relationship (Type, Print)	
To provide the provided Health of the provide	more, MD 21244
2 Para E S	20c. Location - City or Town, State
20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Meachwridge Cemetery 06/05/09	Elkridge, MD
E d	Interest in the
202. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 1 X Burial 2 Cremation 3 Removal from State 1 X Burial 2 Cremation 3 Removal from State 1 X Burial 2 Cremation 3 Removal from State 1 X Burial 2 Cremation 3 Removal from State 22. Name and Address of Facility 22. Name and Address of Facility 23. Name and Address of Facility 24. Donation 5 Other Specify: 25. Name and Address of Facility 26. Name and Address of Facility 27. Name and Address of Facility 28. Name and Address of Facility 29. Name and Address of Facility 29. Name and Address of Facility 20. Name and Address of Facility 20. Name and Address of Facility 20. Name and Address of Facility 21. Signature of Funeral Service Licensee	Cremetion Services
TANITUTI I I I I I I I I I I I I I I I I I	111e, MD 21234
Physician 2 #. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory a failure. List only one cause on each line.	nrest, shock, or heart Approximate Interval Between Onset and
Acute Coronary Artery Thrombosis	Death
or condition resulting in death) Due to (or as a consequence of):	
Sequentially list conditions, b. Hypertensive Atherosclerotic Cardiovascular Disease	
if any, leading to immediate Due to (or as a consequence of):	
cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):	
events resulting in death) Last Due to (or as a consequence of):	
9 7 1 9 1	
VS of the principle of	23d. Date of delivery
99 by St. 15 FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	Month Day Year
past 12 months? 4 Pregnant at time of death 5 Other (Specify)	
So the past 12 months? Other (Specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Fetal death 3 Ectopic pregnancy 5 Other (Specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	tobacco use contribute to the cause of death?
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	Yes 2 No 3 Probably 4 ✔ Unknown
Records. The law requires figure that been signatured by page 2 should be a been signatured by the state of	
24a. Wi au Deproduction of the control of the cont	topsy prior to completion of cause of death?
1 → Ye	s 2 No 1 Yes 2 No
y = y = y = y = y = y = y = y = y = y =	
examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5	Residence 6 Other:
24a. We always a control of the cont	be how injury occurred
Light Second 1 Natural 5 Pending Investigation	
28f. Location Specific Specifi	n (Street and Number or Rural Route Number, City
Very street of the party of the	n, State)
S = F > 1 /98. Lettilet . I a wis . The transfer of the death consumed at the time date and place and due to the c	ause(s) and manner as stated.
28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location or Town 28g. Location or Town 28g. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location or Town 28g. Cattifier 1 28g. Location or Town 28g. Certifier 1 28g. Location or Town 28g. Certifier 1 28g. Location or Town 28g. Place of Injury - At home, farm, street, factory, office building, etc. 28g. Location or Town 28g. Location 28g. Loca	ate and place, and due to the cause(s)
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the correct one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the correct one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the correct one) 29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
Chude Hella Cara O.C.M.E.	May 31, 2009
Coron nucho	
30. Name and address of person who completed cause of death (Item 23a)	
I J V I Don't Aller MAD Assistant Madical Examinary 111 Dans Street Politimary MD 21201	
Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day Year) 2 2009 32. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 8:53 AM **Physician** C. White MAN 2009 Susan 27 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 15 Itimore Hospital BaHimore Of If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2√□ F 20 212-50-5277 Yrs. 11 MD 60 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Extrainst must be a cittled at 1X Yes 2 No Director MD NA Baltimore Susan White 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. Funeral 4216 Nadine Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2X ☐ No Specify: þ Specify: Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CSX Railroad Lead Account Payable Clerk 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland Be Thelma Speaks ဂ္ James White 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4216 Nadine Drive, Baltimore, Md 21215 Kia Rolle-Cousin Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/2/09 Baltimore, Md Green_ Mount 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21215 21. Signature of Funeral Service Licensee Elm Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 3 months Breast Concer **Physician** with metashbu disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to limite flate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dusity for as a consequence off law requires that the death certificate be executed burial-tran Due to (or as a consequence of): attending physician Physician/Medical the ! as IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year for in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) P.O. the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ pe 2 **Y** No 3 Probably 4 Unknown 1 ☐ Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Kenal 24a. Was an has autopsy performe Physician: The certificate 2 No 1 ☐ Yes funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 NO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 24 hours after death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only one and manner stated. within 2. the 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifie

State Registrar trancis

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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				partment of Health and I		ene 2009	1762
	Physi /Med		1. Decedent's Name (First, Middle, Last) Elizabeth R. Waltru	ın	2. Date of Death Month	Day Year	3. Time of Death
	Exam		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	May	31, 2009 4c. County of Deat	
N	Funera	1	Renassance Gardens at Charlestown 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Catonsville If Under 1 Year If Under 24 Hrs.	8 Date of Birth	Baltimor	
	Directo	r	212 42 1272 1 M 2 F 95 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y)	914 D.C	hplace (State or Foreign untry)
	the Maryland 28a-f show	ector	10a. State 10b. County 10c. City, Town or L	ville			10d. Inside City Limits 1 ☐ Yes 27 No
	h with	a Dir	709 Maiden Choice Lane	10f. Zip Code 21228	10g	. Citizen of What Cou	intry?
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a fractical Exercitivat mist be rediffed at once.	d by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 N Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 Yes 20 No Specify:	ecify Yes or No- Rican, etc.)	U.S.A. 14. Race - Amer Black, White Specify: Wh	ican Indian, , etc.
Baltimore, Maryland 21215-0036	d within 72 l giene. er than "nati	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation kind of work done during most of worki DO NOT use retired) nemaker	ing 16t	o. Kind of Business/li	
and	be file tal Hy d othe event,	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maid	Home den Surname)	
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nore	ages 1 nt of H :: If iter		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, crei			. Location - City or To	
altin	mit. Pa partme portani r injury		4 Donation 5 Other (Specify) Cedar Hil			ltimore,	-
8	Depar Depar Impor any in		Hana Manmeroush: 4	001 Ritchie Highwa	ıv Kaltim	l Service	, P.A. land 21225
108	Physician and Medical Examiner the purial-transit the burial-transit	Exa	23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	>	respiratory arrest,		Approximate Interval Between Onset and Death
P.O. Box 68760,	reterning rinstrain: The law requires that the death certificate be exect retern. Settor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-trains.	by Physician/Medical	d	Ectopic pregnancy Other (specify)		23d. Date of delive	ery Day Year
ords,	equires that the sen signed onld be de	ted by F	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacco	use contribute to the	ne cause of death?
Division of Vital Records,	certificate has b ector, page 2 sh	Be Completed	25. Was case referred to medical		24a. Was an autopsy performed?	prior to cor death?	osy findings available npletion of cause of
of V	this ce al direc		examiner? Hospital: 1 Inpatient 2 ER/Outpatient	26. Place of Death 3 DOA Other: 4 Nursing Hom		6 ☐Other (Specify	·
ision	after death. Director: After	Certification: To	27. Manner of Death 1	28c. Injury at Work? M 1	3d. Describe how inj		/
Div	rrs afte	S Certif	28e. Place of Injury - At home, farm, street building, etc. (Specify) 29a. Certifier		City of Town, Sta	,	
of to Ho	vithin 24 h	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death 2 ■ Medical Examiner: On the basis of examination and/or invessed and manner stated.		at the time, date at	nd place, and due to	the cause(s)
			Muse Co	29c. License number	29d. D.	ate signed (Month, E	ay, Year)
	3 State	-	10. Name and address of person who completed cause of death (Item 23a) (Type, Pi 11. Date ded (Month, Day, Year) 32. Register's Signature	n Choice Lan	e Cath	nsville	21278
	State Registra		JUN 0 2 2009 Server Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2009 10:55 PM May Daniel Walsh Wilson 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore Gilchrist Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
June 27 1933 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Months 1 ₩ 2 □ F 75 138-24-6571 Usual Residence of Decedent 10a. State 10b. County Town or Location 10c. City, 10d. Inside City Limits Timonium **Baltimore** MD 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3 Brooking Ct. #202 21093 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian Black, White, etc 1 ☐ Yes 2 ☐ X o If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married white 1 □ Yes 2 □ **X**o Specify: Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Life Insurance Insurance Agent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Stevenson Thomas Kelly Wilson, Jr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3 Brooking Ct. #202, Timonium, MD 21093 Helen B. Wilson/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 5/29/09 Glen Burnie, MD Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 21. Signature of Fu Michael 23a. Part 1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 'ancrean monshy Due to (or as a consequence of) Sequentially list conditions, if one cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9 Unknown 9 Unknown

P.O. Box 68760 Records, Dank Division of Vital Hospital or Attending Physician:

burial-trar as the for signed by the a director, page 2 should within 24 hours after deat To the Funeral Director:

Physician

/Medical

Examiner

Director

Completed by Funeral

Be

Funeral

Director

show

ed other than "natural", or items 23a or 28a-f shor event, the Medical Examinar must be indified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than " any fijury or other traumatic event, the Magnetic event, the Magnetic event, the Magnetic

Physician

/Medical

Examiner

Examiner

within 72 hours after death

Baltimore, Maryland 21215-0036

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 Ectopic	c pregnancy (specify)		23d. Date of delivery Month Day Year
Part II. Other significant condition	s contributing to death but not res	sulting in the underlying	cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death? 2 No 3 Probably 4 Unknow
				24a. Was an autopsy performed.	
25. Was case referred to medical examiner?			26. Place of D	eath (Check only one)	,
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□	DOA Other: 4 Nursing	Home 5 ☐ Residence	6 Other (Specify) WSP VQ
27. Manner of Death Solution Solution	28a. Date of Injury (Month, Day, Year) tion	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		oome, farm, street, factorify)	ory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

AMON NW

32 Registrar's Signature

State Registrar

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

back

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death Month Year **Physician** 2009 /Medical 4c. County of Death 4a. Facility N (If no institution give street and number) tion of Death Examiner N/A Date of Birth (Month, Day, Year) 4-10-1960 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** 1 M 2 □ F Months Days Hours Min MARYLAND 49 216-78-6156 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a State 10b County 10c. City. Town or Location or 28a-f show other traumatic event, the Medical Examiner must be notified at **Funeral Director** 1√Yes 2□No MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 IISA 3505 HILTON RD. or items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Specify: BLACK Baltimore, Maryland 21215-0036 1 □Yes 2XXVo Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) -12-HOOD TECHNICIAN JIFFY LUBE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Mental Important: If item 27 is marked o any Injury or other traumatic eve once. LOIS QUARLES LINDSAY WASHINGTON 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21209 19a. Informant's Name/Relationship (Type. Print) 2203 FALLS GABLE LN. UNIT N BALTIMORE, MARYLAND LOIS WASHINGTON (MOTHER) Date 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State ARBUTUS MEMORIAL PARK 6-5-2009 BALTIMORE, MARYLAND 4 Donation 5 ☐ Other (Specify) HIBNER Name and Address of Facility REDD FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Name and Address of Facility REDD FUNERAL SERVICE 21. Signature of Funeral Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoof, or heart failure. List only one cause on each line. **Physician** disease or condition resulting in death) INK /Medical Due to (or as a conse Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transi resulting in death) Last P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal deat 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown Part II. Other significant conditions contributing to death/but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Were autopsy findings available prior to completion of cause of death? Was an After this certificate has autopsy performe 2 No 1 ☐Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 ☐ Pending investigation s after dec. i □Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and add

(Month, Day,

of death (Item 23a)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** ZemaN arriette L. May 28 2009 11:10 aMh /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Glen Arm 11630 Glen Arm Rd. Apt. L 23 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) August 28 1923 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Washington, PA em 1 □ M 2 🖬 F 85 213 09 0689 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show injury or other traumatic event, the Medical Exantinum must be notified at 1 ☐ Yes 2 😿 No Director Baltimore Glen Arm Maryland 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number "natural", or items 23a or LISA 21057 11630 Glen Arm Road Apt L 23 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ∏Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 □Yes 2 □ **X**o Specify. Specify. à 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Housekeeping-Own Home Homemaker 2 should be filed who and Mental Hygiel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Josephine Chivers Wiley Clark ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is r any injury or other traur 11630 Glen Arm Road Apt. L 23 Glen Arm, Maryland 21057 Ludwig B Zeman (Husband) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State May 30 2009 Baltimore Maryland Metro Crematory Inc 4 ☐ Donation 5 ☐ Other (Specify) iği at e of Funeral Service Cicensee Name and Address of Facility Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a. Part 1. Enter the disease shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) CARDI AC ON GRSTIVE **Physician** /Medical Due to (or as a consequence of): HEART DISEASE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transi be execu Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the IF FEMALE: for use a 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2 NO 3 Probably 4 ☐ Unknown icate has been sig page 2 should b 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy nerform 2 🗆 No 1 ☐ Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one director, Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To funeral c 28b. Time of Injury ie Hospital or Attending Pl n 24 hours after death. ie Funeral Director: After t 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural Accident 5 Pending 1 ☐ Yes 2 No investigation the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie DLING CROSERDADS BALTIMORE 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

			For	State of Maryland	d / Depa	artment of H	ealth and N	Mental Hy	~ /	100	LICOF
		1	State Registrar		Ce	rtificate of L	Jeain 	2. Date of De	Reg. No.	1117	3. Time of Death
	Physicia	_	1. Decedent's Name (First, Middle, Las Richard	Earl		Alford		Month Mary	Day	Year 2007	6922 M
	/Medic	al	4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death			ty of Death	
	Examin	er '	4a. Facility Name (If not institution, give WMHS-Memorial			Cura	herlan	d	All.	eaco	W
.51			5. Social Security Number 6. Se		ast birthday,	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	rth av. Year)	. Birth	place (State or Foreign ntry)
	Funeral Director	.		©M 2□F 62	Yrs.	Months Days	Hours Min.	06/16/	1946	Geor	rgia
			Usual Residence of Decedent								10d. Inside City Limits
, dela	now at		10a. State 10b. County	10c. City	y, Town or L						1 ☐ Yes 2 ☑ No
Mar	a-fs	cto	MD Allega	ny	C1	umberland			10g. Citizen o	of What Cou	intry?
ř Ť	or 28	Director	10e. Street and Number	1 17TH		10f. Zip Code	1502			USA	•
4	23a	la l	14514 Valley R		6 12	1		Specify Yes or N	o- 14. F	lace - Amer	
6	permit. Pages 1 and 2 should be filed within 72 hours after ucean with the waryaning bepartment of Health and Mental Hydiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, Ite Medical Evant and that be natified a sonce.	Funeral	11. Marital Status1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever in U. Armed Forces? 1 ∑Yes 2 ☐ No	3.	Was Decedent of H If Yes, specify Cub		to Rican, etc.)		lack, White,	, etc.
	ll', or	à l	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Spe		White
Maryland 21213-0030	atura	Completed	15. Decedent's Ed (Specify only highest gra	ucation	(Giv	edent's Usual Occup e kind of work done	during most of wo	rking	16b. Kind of	Business/I	ndustry
2 i	e. an "n	를	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	a)		Man	ufact	uring
7	gien gien th	6	12	4		Preside	18. Mother's Na	me (First, Middi			<u>ur 1116</u>
2	tal Hy d oth	Be (17. Father's Name (First, Middle, Last)	rman	Alfo	rd, Sr.	Doroth			anier	
<u>y</u> a	Men Men arke	ျ	114011			ling Address (Street			ber, City or To	wn, State, Z	Zip Code)
9	2 sh n and rism raum		19a. Informant's Name/Relationship (Linda Alford / W		145	14 Valley	Road, N	E, Cumb	erland,	MD	21502
ב ע	1 and Healt em 2 ther		20a. Method of Disposition			position (Name of ematory or other pla		Date	20c. Location		Town, State
2	ages int of int		1 ☐ Burial 2 🂢 Cremation 3 🗆	Removal from State	nherela	and Cremat	ory 05/	17/2009	Cumbe	erland	l, MD
baitimore,	it. Partme		4 ☐ Donation 5 ☐ Other (Special Strategy of Funeral Service Licentary)		nber 1a	22. Name and Addr	ess of Facility Ad	lams Fam	ily Fur	neral	Home, P.A.
g	permi Depa Impo eny I		R DHOO K	Mm		404 Decat	ur Stree	et, Cumb	erland,	, MD	21502
			23a. Parl 1. Emor the disease, or com	plications that caused the dea	th. Do not e	enter the mode of dy	ing, such as cardia	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Nevel eigen		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	· +	i (dr	rang	disc on	7.8		YAJ
į.	Physician /Medical		disease or condition resulting in death)	Due to (or as a consec	quence of):	C	Ó				
	Examiner			Diabeter	Meli	leta					GRS -
		ne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):					Į	1,60
	ecuted nd transi	Examiner	lilat illitiated events	c Due to (or as a consec	augnes of):						
760,	eath certificate be executed attending physician and for use as the burial-transit		resulting in death) Last	Due to (or as a consec	querice oi).						
	ys e	dical	•	_ d							
89 x	ding p	Me	IF FEMALE:	23c. If yes, outcome of pregr	nancy				23d	. Date of de	
Вох	death certifica ie attending ph ed for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	tal death	3 ☐ Ectopic pregna 5 ☐ Other (specify)	ncy		-	Month	Day Year
o	0 0	ysic	1 □Yes 2 □No 9 □ Unknown	9 Unknown				-			
σ.	Physician : The law requires that the de this certificate has been signed by the a ral director, page 2 should be detached l		Part II. Other significant conditions	contributing to death but not re	sulting in the	e underlying cause (jiven in Part I.	23e. D			to the cause of death?
Records	w requires to been significations should be	Completed by	Stage V Ch	rouic Ridre	<u> </u>	Jeseve		- 1	□ Yes 2[\$\frac{1}{2}(, ,	Probably 4 Unknowr
2	w req	lete	Hugestons	2000	0			24a. W	utopsv	prior to	autopsy findings available completion of cause of
æ	The law cate has	l E	- CAPERIO					1 □ Ye	erformed?	death? 1 ☐ Ye	s 2 No
Vital	iclan: The certificate rector, pag	Be	25. Was case referred to medical					eath (Check or			
<u> </u>	iysiclan: iis certific director,		examiner?	Hospital: 1 ☐ Inpatient 2	ER/Outpa	tient 3 L DOA		g Home 5□F			pecify)
	ig Phy ter thi	l ä	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Tim Inju	ry W	ork?	28d. Descri	be how injury o	ccurred	
<u>0</u>	endir sath. or: Ai	atic	2 Accident investigati				□Yes 2□No	28f Locatio	on (Street and	Number or I	Rural Route Number,
Division	r Atter de irecte	Certification: To	3 Suicide 6 Could not determine		nome, farm, cify)	street, factory, offic	е	City of	Town, State)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Sel	200 Cortifier 180 Continue	Physician: To the best of my k	nowledge. d	eath occurred at the	e time, date and pl	ace, and due to	the cause(s) a	ind manner	as stated.
	Host 24 ho. Fune itely fi	Medical	29a. Certifier 1 CertifyIng (Check only one) 2 Medical Ex	Physician: To the best of my k aminer: On the basis of exami and manner stated.	nation and/	or investigation, in m	y opinion, death o	ccurred at the ti	me, date and p	lace, and d	ue to the cause(s)
	o the ithin a	Med	29b. Signature and title of certifier	1	0	29c. Lice	ense number	,	29d. Date	signed (Mo	nth, Day, Year)
	1		1	(Am l	Lu	in Di	12057	1	Ma	N 1	5,2009
	10 +		30. Name and address of person wh	o completed cause of death (I	tem 23a) (Ty	pe, Print)				1	
	nas		Gregg C. Do	valdson 91	25	eton Dr	ive C	umber	land, s	ND.	21502
	S	tate	31. Date filed (Mo)th, Day, Year)	32. Registrar's Sig	nature	Med					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 2009 19 9:40 A May Louise Ammons Judy /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington 16930 Bakersville Road Boonsboro If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Jan. 18, 1943 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Days West Virginia 1 □ M 2 🔀 F Hours 66 236-64-8373 Director Usual Residence of Decedent 10d. Inside City Limits 1∩a State 10b. County 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Expringer must be recitled at 1 ☐ Yes 2 No Director Maryland Washington Boonsboro 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21713 USA 16930 Bakersville Road Funeral within 72 hours after death 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2√∏Xlo Specify þ 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Credit Card Processing Data Entry Clerk 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi Stonebreaker 1 and 2 should b Health and Ment tem 27 is marked Wanda Virginia Douglas Washington Love ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9922 Fieldstone Drive Hagerstown, Maryland 21740 Roger H. Ammons - Son permit. Pages 1 and Department of Heath Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Lawn Mem. Park May 22,2009 Hagerstown, Maryland 5 Other (Specify) OSborged Afterestality Home, P.A. 21. Signature of Funeral Sa 425 S. Conococheague St.Williamsport, MD 21795 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to for as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed burial-transit Exami and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ned by the attending physician detached for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months Month Day Year 5 Other (specify) □Yes 2 No 9 I Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | → NO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica within 24 hours at lot the Funeral D completely filled it 0

> State Registrar

DHMH 17 Rev 1/2001

Date filed

(Check only

29b. Signature and title of certifie

ASS 111 Registrar's Signature

29c. License number

GIKI

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month 14, 2009 **Physician** 11:25P [™] Rose M. Armstrong May /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Fox Chase Rehabilitation Center Silver Spring Montgomery 8. Date of Birth (Month, Day, Year)
Dec. 22, 1950 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 213-56-2890 6. Sex **Funeral** Months Days Hours 1 □ M 2 🔀 F 58 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at Montgomery 1 XYes 2 No Md Germantown Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20874 19729 Crystal Rock Drive U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed by 3 ☐ Widowed 4 € Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Private Family d 2 should be filed within th and Mental Hygiene. 7 is marked other than ' Elementary/Secondary (0-12) 12 College (1-4or 5+) Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eunice Fuller George Armstrong ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Frank Armstrong- Uncle 7901 Good Luck Road, Lanham, Md. 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Beltsville, M.D. May23,09 Chesapeake 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Robinson Funeral Home 1313 6th St.NWWash 22. Name and Address of Facility 21. Signature of Funeral Service Licensee O lun E 23a. Part1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ovarian Cancer- Metastatic Physician 3 Months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: nse yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy 2 Fetal death ō in the past 12 months? Month Day Year 5 Other (specify) N/AI ☐ Yes 2 🕱 No detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Junknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? Ves 2 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this the funeral 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 27. Manner of Death 28c. Injury at Work? After (Month, Day Year) 5 Pending investigation 1 XNatural М 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funeral DI completely filled in Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number D28656 29b. Signature nd title of certifier

State

31. Date filed (Month, Day, Year) MAY 1 8 2009

Ravi Passi MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15225

Shady Grove Road Rockville Md. 20851 32. Registrar's Signature

Registrar

May 15, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) 2009 14 May **Physician** Larmina 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months AFGHANISTAN 1 M 2 KF 219-35-4870 53 Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event. the Medical Examinar models. 10c. City, Town or Location 10a. State 1 X Yes 2 No Funeral Director 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 22310 USA 6025 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify Specify: Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) College (1-4 pr 5+) Elementary/Secondary (0-12) maker Home 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be AHIMA HOSSAINKHAI ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Husband lexandria VA.22310 Bitternut DY. GHOLAM 20c. Location - City or Town, State
Alexandria 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 16/2019 Mount Comfort Cem > /16/2071 22. Nam and Address of Facility Aden M Signature of Funeral Service Licensee Bull street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (* as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23d. Date of delivery nse 23c. If yes, outcome of pregnancy Live birth 2 | Fetal death Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year Live birth in the past 12 months? 5 Other (specify) 2 X No is been signed by the a 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No I or Attending Physician: The law after death.

Director: After this certificate has I 2 🗌 No 1 Tes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? filled in by the funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 - ER/Outpatient 3 - DOA 1 ☐ Yes 2 No ၉ 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 5 Pending investigation Injury 1 Natural 2 \ No 1 Tes 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Hospital 24 hours a Funeral C 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 hor To the Funer completely fil Medical (check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year 18 2009

Registrar's Si

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 Evelyn Brady May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Allegany WMHS-Memorial Campus Cumberland If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 □ M 2 🏋 F 84 219-14-6494 Yrs. 06/01/1924 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Director MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 1023 Penhurst Street Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify. 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Registered Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond Luther Beck, Sr. Pauline Frances Dean 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 622 White Avenue, Cumberland, MD W. Patrick Brady, Jr. / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/20/2009 St. Mary's Cemetery : Cumberland, 21. Signature of Funeral Service Ligense 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End Stare Chronic Obstructive Pulmonary Disease 10 years Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of, Due to (or as a consequence of). Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Be Completed by

Physician /Medical Examiner

Physician

Funeral

Director

show

ral", or items 23a or 28a-f shore Examiner must be notified at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be in nent of Health and Mental int: If item 27 is marked o

nt of Health a

other

6

Department of Important: If any Injury or once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlan-transit

Division of Vital Records, P.O. Box 68760,

1 □Yes 2 🔀 9 □ Unknown	ĪNo	4 ☐ Pregnant at time of 0 9 ☐ Unknown	death 5 ☐ Other ((specify)		
Part II. Other signific	cant conditions o	ontributing to death but not res	ulting in the underlying	cause given în Part I.		se contribute to the cause of death? ☑ No 3□ Probably 4□ Unknown
	<u> </u>				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referre	ed to medical	·		26. Place of D	eath (Check only one)	
examiner? 1 ☐ Yes 2 🙀 N	Vo	Hospital: 1 ☑ Inpatient 2 □	ER/Outpatient 3 🗌	DOA Other: 4 Nursing	Home 5 Residence 6	G ☐ Other (Specify)
27. Manner of Death 1 ☑ Natural 2 ☐ Accident	5 Pending investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	y occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At he building, etc. (Special	ome, farm, street, factory)	ory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
29a, Certifier	1 Certifying Ph	ysician: To the best of my kno	owledge, death occurre	ed at the time, date and pla	ace, and due to the cause(s)	and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D0014865 29d. Date signed (Month, Day, Year)

May 18, 2009

2

nes

31. Date filed 7 9 2009 State

29b. Signature and title of certifier

(Check only

Robustiano J. Barrera, M.D., 500 Memorial Avenue, Cumberland, MD 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

Certification: To

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 16:20 M Blubaugh MAY 12, 2009 Virginia Kathryn /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ALLEGANY CUMBERLAND WMHS - MEMORIAL CAMPUS Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Hours Months Days 1 ☐ M 2 👿 F 61 Director 04/25/1948 West Virginia 217-54-6707 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show or than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 ▼No Director PABedford Hyndman 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3572 Hyndman Road 15545 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any Injury or other traumatic event, it is Medical Experient must any Injury or other traumatic event, it is Medical Experient must genee. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 🎇 Married Baltimore, Maryland 21215-0036 1 ☐Yes 21 No Specify Specify. White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hospital Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Ford Esther ပ Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Eugene F. Blubaugh / Husband 3572 Hyndman Road, Hyndman, 15545 PA 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Davis Memorial Cemetery 05/16/2009 4 ☐ Donation 5 ☐ Other (Specify) Cumberland, MD 21. Sign ture of Funeral Service License 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 23a. Part 1. Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. nd Death Immediate Cause (Final **Physician** disease or condition resulting in death) COCKIACO /Medical Due to (or as a consequence of): Examiner DIABETE Sequentially list conditions n any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a somequence of). Examine Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician for use as the buria P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? rt II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) 1∐Yes 2**⊠**No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Appatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

within 24 hours after death

To the Funeral Director:
completely filled in by the 1

29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

()\$ SETON DRIVE, CUMBERLAND, MD 21502 ROBERT A., M.D., 32. Registrar's Signature

State Registrar

Medical

29a. Certifier

2

nes

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** P^{M} 5:50 Bosley Lila Jean 2009 May /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Potomac Manor Care Potomac Hours Min. June 13, Birthplace (State or Foreign Country) If Under 1 Year Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 F 217-28-6716 77 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show ed other than "natural", or items 23a or 28a-f showevent, the Maxical Examiner must be notified at 1 ∐Yes 2∤ 🗌 No Director MD Montgomery Bethesda the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" ~ " any Injury or other traumatic event and increase." 8412 Magruder Mill Court 20817 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 ∐Yes 2X No 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 🖾 No Specify: White 2 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harris Burruss Davenport Nettie Mae Grimm ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8412 Magruder Mill Court, Bethesda, MD Michael Bosley 20817 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5-19-2009 4 Donation 5 Dother (Specify) Gate of Heaven Cem. Silver Spring, MD 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service 5130 Wisconsin Ave. N.W., Washington, D.C. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each time. Approximate Interval Between Onset and Death Immediate Cause (Final Advanced Dementia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. End of June 19 Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and telly filled in by the funeral director, page 2 should be detached for use as the burial-transit netsy filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed?

1 Yes 24 No 1 ☐ Yes 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: AND Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0054566 5-15-2009 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Sunith Bhogavilli 9801 Georgia Avenue #1-17, Silver Spring, MD

Registrar

State

31. Date filed (Month, Day, Year)

18

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2009 6:50 рм **Physician** Mary Elizabeth Bakewell May 17, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carroll Carroll Hospice Dove House Westminster 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🗷 F Pennsylvania 177-16-7824 87 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ith and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Extrair sermant be notified at Finksburg 1 ☐ Yes 2 No Carroll Directo Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21048 3063 Old Gamber Road USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Malik Benjamin Franklin Seese ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau 3063 Old Gamber Road, Finksburg, MD 21048 William G. Bakewell, husband 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 Kemoval from State Lafayette Memorial Pk 05/21/2009 Brier, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service Licensee Willis Street, Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 ☑No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Many of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide

Physiclan: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit Box 68760, P.0. Division of Vital Records, this al or Attending P after death. I Director: After I d in by the funera After 1 completely filled in by To the Hospital or within 24 hours af To the Funeral D

filed within 72 hours after death with the Maryland

pe

Saltimore, Maryland 21215-0036

28a-f show

WIL 4

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

and manner stated.

eth (a

State Registrar

Medical

29a. Certifier

29h Signatu

(Check only

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician Heath Balic /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balt: nore Shock T-auna Center

[ex 7. Age (In yrs. last birthday) Conley Hams If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 M 2 □ F 24 Months 213-27-9771 Director 20,1984 Michigan Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Department of Health and Mental Hyglene.

In proportant: If item 27 is marked other than "natural", or items 23a or 28a-f shou any Injury or other traumatic event, Ire Medical Expringer must be notified at once. Anne Arundel MD Arnold 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 358 Carronade Way 21012 USA Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

1 X Yes 2 U No Desert
If Yes, Give
Year or Dates: Storm 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ò White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sheet Metal Worker Union Local 100 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lawrence R. Balick Beth S. Crane ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence R. Balick / Father 1174 Green Holly Drive Annapolis, MD 21409 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory, May 14, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Glen Burnie, MD LLC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) 10 days **Physician** Complication /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and -tran Due to (or as a consequence of): the burial Division of Vital Records, P.O. Box 68760 Physician/Medical as attending for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown cate has been si page 2 should b 1 🗌 Yes Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 No 1 ☐ Yes 2 ☐ No funeral director. Be 25. Was case referred to medical examine?
1 ☐ res 2 ☐ No 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 023FA 99 1 ☐ Yes 2 ☐ NO 2 Accident investigation Substance Abuse 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 286 filled in by 4 ☐ Homicide Transe

15 Caronade Hay M

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my children in the cause (s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 09 MID

State Registrar

DHMH 17 Rev 1/200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William C Chiu

Saltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 8:30 P M 2009 May 12, Evelyn Genevieve Bodfield Baker /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's 2800 Liberty Place Bowie Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, **Funeral** Months Days Hours 1□M 2AF 14, 1925 Nebraska 84 Feb. Director 505-22-5377 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County ral", or items 23a or 28a-f show X Yes 2 No Directo Maryland Prince George's Bowie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with to ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or: ury or other traumatic event, Inc. Madical Extrainer must be re USA 20715 2800 Liberty Place Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify Specify: Completed by White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Home Maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leona Mae Brandt ပ္ Alonzo Jackson Bodfield permit. Pages 1 and 2 shoul
Department of Health and M
Important: If item 27 Is marl
any injury or other traumati
once. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2800 Liberty Place Bowie, MD 20715 Robert Baker/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lincoln
Memorial Park 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 5/22/2009 Lincoln, Nebraska 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licenses 16000 Annapolis Road Bowie MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final T- cell utaneous **Physician** mos. disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Que to for as a consequence off or Attending Physiclan: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Year Month Dav 4 ☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. s been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ ceve 600 vascular disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b autopsy performed?

1 □ Yes 2 3 No 1 ☐ Yes 2 ☐ No certificate director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 5 Pending investigation 1 Natural ours after death.

neral Director: Af
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital 24 hours a 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

900 Bestgate Rd. Annapolis, Md. 21407

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Selonick, mo

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 27^{Day} Month **Physician** 2009 May Phyllis Lorene Cleveland 5:45 A. M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Buckingham's Choice Health Care Adamstown Frederick 8. Date of Birth (Month, Day, Year) 12/12/1927 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Country)
Indiana Months Days Hours Min 1 ☐ M 2 💢 F 81 Director 310-28-5131 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County 28a-f show ral", or items 23a or 28a-f shore Examiner must be notified at 1 ☐ Yes 2 No Director MD Frederick Adamstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene, Important: If item 27 is marked other than "natural", or items 23a or a Important: If item 27 is marked other than "natural", or item 23a or any Injury or other traumatic event, the Modical Examination of the traumatic event, the Modical Examination of the property of 3200 Baker Circle I-10821710 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give². Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify Specify: Completed by white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) education librarian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kenneth Walter Sheeks Bass Lorena 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3200 Baker Circle, I-108, Adamstown, MD 21710 Merrill Cleveland / husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/28/2009 Smithsburg Crematory Smithsburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney & Basford Funeral Home Janjula Much MO1222 106 East Church Street, Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 10 Day 9 DNEUMINIO /Medical Examiner Sequentially list conditions, if any, I ading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the b attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year signed by the a 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ as been si 3 Probably 4 Unknown 1 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? s certificate ha irector, page 2 1 Tyes After this certific funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one, Other: 1 ☐ Yes 2 No 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending n 24 hours after death.

Refuneral Director: A pletely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 😭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of dertifie

Q

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** P^{M} 2009 1750 Dorothy M. Crouse Mav /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Ceci1 E1kton Laurelwood Care Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours OCT 2, 1919 Pennsylvania Director 89 207-14-3792 Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the worldst Even, in a factoral Even. 1 ¥ Yes 2 □ No Director Ceci1 E1kton Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21921 United States 100 Laurel Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🗓 No Specify: þ Specify: 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 7 I Hygiehe. Elementary/Secondary (0-12) College (1-4or 5+) In Her Own Home Homemaker 12 should be filed with and Mental Hygiel 7 is marked other th 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred Bondy George Marinkovich 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) per nit. Pages 1 and 2 s
De artment of Health ar
Important: If item 27 is
any Injury or other trau 103 Cherry Tree Lane, Elkton, James G. Crouse/Son MD21921 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gilpin Manor
Memorial Park 20c. Location - City or Town, State 20a. Method of Disposition May 28 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Elkton, MD 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, 21. Signature of Funeral Service Licensee 21921 Approximate Interval Betweer Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical consequence of): Examiner anda Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of Physician: The law requires that the death certificate be executed and burial-tran as a consequence of) P.O. Box 68760, the attending physician Physician/Medical the ! use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) detached 9 Unknown s been signed by the should be detach 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 🗆 No 2 410 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 N Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t or Attending Division 1 Natural 5 Pending 1 ☐Yes 2 ☐ No death, investigation 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 1 - For State Registrar Certificate of Death 1 Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death Month Pay 14 2009 **Physician** May 550 A M Joan Madonna Cox /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Gaithersburg 447 Upshire Circle If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 01/12/1948 Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 □ M 2 🗓 F Towa 61 485-56-6202 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location show 10a. State 10b. County d other than "natural", or items 23a or 28a-f shovevent, the Widtel Evaluation Yes 2 No Director MD Gaithersburg Montgomery 10a. Citizen of What Country? 10f, Zip Code 10e. Street and Number United States 20878 447 Upshire Circle by Funeral death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify Specify. 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) E.P.A. (Private) Consultant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Jennie Accurso Unobtainable Stephenson ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 is other tra 2615 Hunter Mill Road, Oakton, VA Zachary A. Smith/Nephew 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 ŏ permit. Pages Department of Important; If it any Injury or conce. 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Fort Lincoln Crematory 05/18/09 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simple Tribute 21. Signature of Fuperal Seprice Licenses 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line. Approximate Interval Between Onset and Death Immediate arme (Final disease or condition resulting in death) Physician Chronic Obstructive Pulmonary Disease Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if only to ling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical LE FEMALE yes, outcome of pregnancy
Live birth 2 Detail death
Description 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) s been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Pneumonia Completed cate has been a 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2払No 24a Was an autopsy
performed?

1 Yes 2 ANO certificate ours after death.

leral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 14, 2009 D53317 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Austin Ball M.D., 16220 Frederick Road, #213, Gaithersburg, MD 20877 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

			For State	State of M	aryland		artment of F		nd Mental F		0000	17600
			Registrar 1. Decedent's Name (First, Middle, Li	ast)			rtificate of	Death	2. Date of	Reg. I	No. 2 1 1 9	3. Time of Death
	Physici		FRANCES C						Month MAY		Day Year 2009	4:19 P M
-	/Medi Examir		4a. Facility Name (If not institution, gr				4b. City, Town, or	r Location of I		<u> </u>	4c. County of Deat	
91			Holy Cross Hospital				Silver				Montgomery	
	Funeral			1 M 2 SZ E		i <i>st birthday)</i> Yrs.	If Under 1 Year Months Days		Min (Month.	Birth Day, Yea		hplace (State or Foreign untry)
	Director		579-20-7338 Usual Residence of Decedent	- 4 8	6	113.			Dec. 5	19	22 Wash	ington, DC
	yland how		10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
	ath with the Marylan 23a or 28a-f show ust be retified at	ctol	Maryland Montgome	ry	Sil	ver Sp	ring			,		1 XYes 2 No
	vith th	Dire	10e. Street and Number				10f. Zip Code				Citizen of What Co	
	eath v	eral	10000 Brunswick Aven	ue, Apt. #324		13	20910	lienanie Origin	2 (Specify Vas or		Inited State	
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "drail Evricing", ust be nearlied and once.	by Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🖔 If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cuba 1 □Yes 2ᡌNo	an, Mexican, F	Puerto Rican, etc.)	NO	Black, White	
2-0	72 hou	ted	15. Decedent's E	ducation		16a. Dece	dent's Usual Occup	ation	f warking	16b	. Kind of Business/	
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2	iled w Hygie ther ti	S	12 17. Father's Name (First, Middle, Las	<i>t</i>)		Туј	pist	18 Mother's	Name (First, Mide		deral Gover	rnment
Maryland 21215-0036	d be f ental ced o c eve	To Be	Domenico Chite	•					,	Ciome		
aryl	shoul and Ma marl umati	F	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailii	ng Address (Street				ty or Town, State, Z	Zip Code)
Ĭ,	and 2 saith s 1 27 is er tra		Victoria M. Keetay,	niece		1417	Alston Plac	e, Apt.	#135 Res	ton,	Virginia	20194
Baltimore,	of He if item		20a. Method of Disposition 1 X Burial 2 Cremation 3 [Remove from State	20b. Pla	ace of Dispo	sition (Name of matory or other place	ce)	Date	20c	. Location - City or	Town, State
Ë	E. Pag tment tant: I		4 □ Donation	(5)	Gate		ven Cemeter		18/2009	Si	lver Spring	, Maryland
Bal	permit Depar Impor any in		21. Signature of Funeral Service Lice	h tu	i.		2. Name and Addre L800 New Hai		Hines-Rina Avenue, Si	ldi F lver	Funeral Home Spring, MD	e, Inc. 20904
			23a. Part 1, Enter the diseas-, o cor shock, or heart failure. List only	nplications that caused one cause on each li	d the death. ne.	Do not ent	er the mode of dyir	ng, such as ca	ardiac or respirator	y arrest,		Approximate Interval Between Onset and Death
	Physician	1	Immediate Cause (Final disease or condition resulting in death)	a. Respirato								Oriset and Death
	/Medical Examiner		and the second s	Due to (or as Seizure	a conseque	ence of):						
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a conseque	ence of):						
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90,	oe exe cian a urial-t	EX	resulting in death) Last	Due to (or as	a conseque	ence of):						
68760,	cate t physic the b	edical	•	d								
Вох в	eath certificate be executed attending physician and for use as the burial-transit	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			7				23d. Date of del	ivery
O. B	Attending Physician: The law requires that the death certificate be executed redeath. redeath. cotor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/M	in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown			☐ Ectopic pregnanc ☐ Other (specify)	У		-	Month	Day Year
ς, G.	s that gned b	by Pl	Part II. Other significant conditions	contributing to death b	ut not resul	ting in the u	nderlying cause giv	en in Part I.	23e. D	id tobaco	co use contribute to	the cause of death?
ord	w require been si should b		Aortic Valve R	eplacement					_ 1	Yes	2 No 3 Pr	obably 4. Unknown
of Vital Records,	law r has be	Completed							24a. W	itopsy	prior to o	topsy findings available completion of cause of
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VIE	ysician: The law is certificate has t director, page 2 s	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:			oth Oth	or-	f Death (Check on	- /	- 50	
o	ding Phys n. After this funeral dii	n:To	27. Manner of Death	28a. Date of Inju	Jry :	28b. Time o	1 3 LI DOA	4 ⊔ Nurs			e 6 ☐ Other (Spe njury occurred	cify)
ion	inding Fath. ath. ir: After ie funera	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	ıy, Year)	Injury		k? Yes 2∐No)			
Division	l or Attend after death. Director: / I in by the fi	Certification: To	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined	28e. Place of In	ury - At hor c. (Specify)	ne, farm, str)	eet, factory, office		28f. Locatio City or	n (Street Town, St	t and Number or Ru tate)	ural Route Number,
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C		hysician: To the best miner: On the basis of	of examinati							
	omple	Mec	29b. Signature and title of certifier	and manner st	utou.		29c. Licens	e number		29d.	Date signed (Monti	h, Day, Year)
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	5		30. Name and address of person who				Print)				<u> </u>	
			Majid Rahmanian, 31. Date filed (Month, Day, Year)		orest (ad, Silver	Spring,	MD 20910			
	Sta Registr		MAY 18 20		ur a signati	ha	Med.					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 4,2009 Year **Physician** 2120 M Calderon Irene /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5/15/1937 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday)
71 Yrs. 5. Social Security Number 6. Sex **Funeral** Months Days Min. Hours Colombia 1 □ M 2 1 F 216-23-2940 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at MD 1 ☐ Yes 2 ANo Montgomery Takoma Park Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20912 7620 Maple Avenue USA by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Specify: White 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1X Yes 2 No Specify:Colombian If Yes, Give Year or Dates: 3 Widowed 4 Divorced "natural" er than "natura", the Medical E Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unemployed none permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien Important: If Item 27 Is marked other the any injury or other traumatic event, the ORGE. 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ines Calderon unknown ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 0 9 0 3 19a. Informant's Name/Relationship (Type. Print) 717 University Blvd.East #2 Silver Spring,Md Teresa Mancilla/Friend 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Chesapeake Crem. 5/18/2009 Beltsville, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License PHYTE TO Address RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Severe Sepsis /Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🗷 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ failume to thrive 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 🖾 No certificate 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊠No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 5 Pending investigation 1 🔀 Natural of the content of the 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number May 5,2009 D63579 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Rd Silver Spring, Md 20910 Tayag Maria 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Springdale Utica Place 9623 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Davs Min Hours 1 M 2 F 43 Washington DC 577-94-5015 April 3, 1966 Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County 28a-f show ed other than "natural", or items 23a or 28a-f shove event, the "medical Examinar must be netified at Springdale M D 1¥ Yes 2 □ No Prince Georges Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20774 9623 Utica filed within 72 hours after death I Hygiene. Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 □Yes 2 No 11. Marital Status 1 Never Married 2X Married Baltimore, Maryland 21215-0036 Black 1 □Yes 2KNo If Yes Give à 3 Widowed 4 Divorced Year or Dates Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hospital Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant 12th permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygi Important: If item 27 is marked other any Injury or other traumatic event, It 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Beatrice Bussie Ronald Jackson 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Utica Place, Springdale, MD Kenneth F. Clay / husband 9623 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Landover, MD National Harmony Park 5/15/2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service Licenses Indie 7400 Georgia Avenue, NW, Washington DC 20012 Jho Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final acen **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit and Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buris the death certificate be Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 C Ectopic pregnancy signed by the atte in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown certificate has been s irector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No or Attending Physician: 24 hours after death.

Funeral Director: After this certific letely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2. No 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27, Manner of Death 5 Pending investigation (Month, Day, Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical within 2 To the

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State Registrar

29b. Signature and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print)

NICHARL J. La FENTINM (4) DEFENSE HIGHWAY ANNAPOLIS 31. Date filed (Monti

29c. License number

29d. Date signed (Month, Day, Year)

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	_		Registrar 5/18/09 AACO HI 1. Decedent's Name (First, Middle, Last)	ALIH DEPT. CMH		tinouto or B		2. Date of Dea	ath		of Death
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100	/Medic		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or I	Location of Death	1 11 1	4c. County of		
يكبر	Examin		The Johns Hopkins Hos	spital		Baltimore	City				
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	. last birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birt	h v. Year) 1968	9. Birthplace (State Country) MD	or Foreign
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	sath v	Funeral	3030 Steamer Rd.	2. Was Decedent Ever in	J.S. 13.	21613 Was Decedent of His		ecify Yes or No-	USA 14. Race	American Indian,	
	item	Ë	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ★ No	3.0.	Was Decedent of His If Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)	Black,	White, etc.	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ont, the Medical Examiner must be notified at	þ	3 ☐ Widowed 4XXDivorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 💥 o	Specify:		Specify:	White	
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215	hin 7: In "na Medic	ble	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	life.	DO NOT use retired)	anng most or work	mg			
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Maryland	12 sho h and 7 is ma rrauma		19a. Informant's Name/Relationship (Type Jeffrey B. Crutchl			ing Address (Street a				:ate, Zip Code)	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition	20b	. Place of Disp	osition (Name of matory or other place	1	Date		ity or Town, State	
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	(DA		38. Name and address of person who co	ompleted cause of death (Item 23a) (Type						
-	1/2		EMILY SPEEL		PhD		600	North W	olfe St, Ba	timore, M	ى, 21287
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 19, 2009 1:00A.IM. MAY Margaret Ε. Dorsey /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Reeders Memorial Home Boonsboro Washington If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 7, 1919 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Months 1 ☐ M 2 🗓 F 214-09-3822 Maryland Director 90 Usual Residence of Decedent 10d. Inside City Limit 10c. City. Town or Location death with the Maryland 10b. County 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 □ Yes 2 Director MD Washington Smithsburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21925 Beaverbrook Dr. 21783 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Specify þ 3 Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Andrew Forsythe Ruth Cline ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cynthia L. Crilly/Daughter 21925 Beaverbrook Dr., Smithsburg, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 5/21/2009 Hagerstown, MD Rest Haven Cemetery 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Sevire Chronce Olstmuture Disease weeks Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine al or Attending Physician: The law requires that the death certificate be executed after death. Cordian Wiels Stege that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 DiUnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an was autopsy performed? 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Medical Certification: To After this 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director; A 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301-432-8470 BOONSBORO, MARYLAND 21713 20311 LAPPANS ROAD, GHAZALA QADIR, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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Funeral Director		5. Social Security Number 212-01-3735 Usual Residence of Decedent	Sex 7. Ag	ge (In yrs. 1	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day July 0	2 1919	9. Birthp Cour	place (State of htry) M	or Foreign D
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and 2 shu ealth and n 27 is m		19a. Informant's Name/Relationship (Deborah Zerner/o	. ,			ng Address <i>(Street</i> Gahle Dr		_{Iral Route Numbe} tminster		State, Zip .157	Code)	
permit. Pages 1 an Department of Hea Important: If item 2 any Injury or other		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □		20b. P		sition (Name of natory or other place	ce)	Date	20c. Location - 0	•		
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te be executed slocian and burial-transit	al Examiner	Sequentially list conditions, i.e.,	b									
eath certifical attending phy for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 OHO	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal	Ideath 3	Ectopic pregnanc	у		23d. Date Mor		,	Year
res that the d signed by the be detached	b	Part II. Other significant conditions of	contributing to death b	out not resu	ulting in the u	nderlying cause giv	en in Part I.		obacco use contri			
0 - 0	Completed							24a. Was a autop perfor	an 24b. W	/ere auto	psy findings mpletion of c	available
	Be	25. Was case referred to medical examiner?	Hospital:			1045		ath (Check only or			2 110	
g Phys er this eral dir	n: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Inju	ıry	ER/Outpatier 28b. Time of		4 LI Nursing F	ome 5 Resid	dence 6 ☐Othe	` '	y)	
Attending Physician: r death, ector: After this certific by the funeral director,	catio	1 ≝Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b			Injury	M 1 🗆	k? Yes 2□No					
tal or At s after d al Direct ed in by	Certification:	4 Homicide determined	28e. Place of Inj building, et	ury - At ho c. <i>(Specif</i>)	ome, farm, stro y)	eet, factory, office		28f. Location (S City or Tow	Street and Numbe n, State)	er or Rura	.l Route Nun	nber,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical		nysician: To the best niner: On the basis of and manner st	of examina								s)
で Sometiment of the property	Σ	29b. Signature and title of certifier	udelleto	in 1	ni)	29c. Licens	e number		29d. Date signed	(Month,	Day, Year)	
W3		John W. Mido	completed cause of c	death (Item	311	Print)	rest v	nmel	is ten i	MD	2110	2
Sta Registr		31. Date filed (Month, Day, Year) MAY 19	32. Registr	ar's Signa		be. N. I			,			
		MALTO	LUUJ REN	CANB A	14. M	Parker				·		

Physici /Medic Examin

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any liutry or other traumatic event, the Madical Extrairest restricted an any liutry or other traumatic event, the Madical Extrairest restricted an any liutry or other traumatic event, the Madical Extrairest restricted an any liutry or other traumatic event, the Madical Extrairest restricted as any liutry or other traumatic event, the Madical Extrairest restricted and once.

Baltimore, Maryland 21215-0036

/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Physician To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	Registrar	Cei	titicate of i	Death		Reg. No. 👇 🖣	100 11044
	1. Decedent's Name (First, Middle, Last)				2. Date of De Month	eath Day	3. Time of Death
ın al	Lucille Diggs				May		009 6:23 P M
aı er	4a. Facility Name (If not institution, give street and number)	Apt	4b. City, Town, o	Location of Dea	th	4c. Count	
	11316 Fort Washington Rd.	202	Fort	Washing	rton	Prin	ce George's
	5. Social Security Number 6. Sex 7. Age (In yrs. I		If Under 1 Year	If Under 24 Hrs Hours Min	8 Date of Bi	rth	9. Birthplace (State or Foreign
	577-52-4219 ¹□м ⅔F 7	O Yrs.	Months Days	Hours Will	Oct 7	1938	D.C.
	Usual Residence of Decedent						40d Incide O't disease
_		, Town or Lo					10d. Inside City Limits
cto	MarylandPrince George's F	ort W	ashingt	on			1 □Yes 2MNo
Be Completed by Funeral Director	10e. Street and Number	Apt	10f. Zip Code			10g. Citizen of	What Country?
<u>a</u>	11316 Fort Washington Rd.	202	2074	4		USA	
nue	11. Marital Status 12. Was Decedent Ever in U. Armed Forces?	S. 13. \	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (an, Mexican, Puer	Specify Yes or N rto Rican, etc.)	o- 14. Ra Bla	ice - American Indian, ack, White, etc.
ΥĒ	1 ☐ Never Married 21X Married 1 ☐ Yes 2 1X No If Yes, Give		1 □Yes 2 X □No	Specify:			b: Black
q p	3 ☐ Widowed 4 ☐ Divorced Year or Dates:						CONTRACTOR DESCRIPTION
lete	15. Decedent's Education (Specify only highest grade completed)	(0)	dent's Usual Occup kind of work done	4 to second of a	orking		Business/Industry
E	Elementary/Secondary (0-12) College (1-4or 5+)	iite. L	NOT use retired	Transpo	ortatio	n F	aith.
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	Troy Holbrooks				s Harr		no)
ဥ		T			•		
	19a. Informant's Name/Relationship (Type. Print)		•				n, State, Zip Code)
	LaGrand E. Diggs(Son) 20a. Method of Disposition 20b. P		7 Jerim		Date BOW		- City or Town, State
	I ITABURAL 2 I I Cremation 3 LI Removal from State		sition (Name of hatory or other place				•
			1 Park	1	15-09	1	ver, Md.
	21. Signature of Funeral Service Licensee **Race M 0 0 4		mame Redes 21 West			_	
	23a. Part 1. Enter the lisease, or comilications that caused the death						Approximate
	shock, or heart failure. List only one cause on each line. Immediate Cause (Final		Maten	1 110	onen		Interval Between Onset and Death
	disease or condition resulting in death) Due to (or as a consect	unce of	11 Kiok	y dis	CHOC		
	1) when	FPC.	Mellit	715			
e	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence)	uence of):	VI CVIII	47			
틆	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	7)15+	nictive	Pulmon	ARIM	1 Sease	
Exa	resulting in death) Last Due to or as a consequence of the consequenc		70(1 0011	700	V- 117 -	
g	HVDer.	tensi	UN		,		
edic		*				1	
n/Medical Examiner	IF FEMALE: 23c. If yes, outcome of pregna 23b. Was decedent pregnant	ncy				23d. D	ate of delivery
cia	in the past 12 morths? 1 ☐ Live birth 2 ☐ Fetal 1 ☐ Ves 2 ☐ No 1 ☐ Live birth 2 ☐ Fetal	Ideath 3L leath 5□	Ectopic pregnand Other (specify) _	у		M	onth Day Year
ıysi	9 Unknown						
y P	Part II. Other significant conditions contributing to death but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use cor	ntribute to the cause of death?
Q D					1 🗆	Yes 2 № No	3 Probably 4 Unknown
lete					24a. Wa	s an 24b.	. Were autopsy findings available
Ę					. I auto	opsy formed?	prior to completion of cause of death?
Medical Certification: To Be Completed by Physicia	25. Was soon referred to medical			00.51	1 □ Yes	2 L¥ No	1 □Yes 2 □No
Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐	ED/C + "	oth	or:	eath (Check only		Ab (O (1)
Ë.	1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ 27. Manper of Death 28a. Date of Injury	28b. Time of	IL 3 LL DOA	4 Li Nursing		sidence 6 101 how injury occu	
ion	1 Natural 5 Pending (Month, Day, Year)	Injury	Wor	Yes 2 □ No	200. Describe	Thom injury occu	1100
ical	3 Suicide 6 Could not be 290 Place of Injury. At he	me farm str		163 2 1110	28f Location	(Street and Num	nber or Rural Route Number,
erti	4 Homicide determined building, etc. (Specifi	y) , (a , o	out, radiory, omou		City or To	wn, State)	is of or right real or
ن =	29a. Certifier 1 Certifying Physician: To the best of my kno	wledge deat	h occurred at the ti	me date and plac	ce and due to th	e cause(s) and r	manner as stated.
lica	(Check only one) 2 Medical Examiner: On the basis of examina and manner stated.						
Me	29b. Signature and title of certifier		29c. Licens	e number		29d. Date sign	ed (Month, Day, Year)
)	tan 2 - Day		Dago	4077	7 200	1. 1	5/12/100
	your focus of the	000 / 75	Drint Variation	70 ora	MINTE	notuci	0/12/07
	30. Name and address of person who completed cause of death (Item	i∠3a) (Type,	T CVI	n Ford	, MD	110	ol orac
14.	31. Date filed (Month, Day, Year) 32 Registrar's Signa	ture	1001	M11 11	KH1)	NO -	7-1-0

State

Registrar

MAY 15 2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 4 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 00:30 AM KAREN SHOWELL DEATH MAY 14 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Shady Grove Adventist Hospital Rockville Montgomery Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🔀 F 184-34-4179 66 Sept. 4 1942 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 1X Yes 2 No Director Md. Montgomery Rockville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20850 10100 Sterling Terrace Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗹 No Baltimore, Maryland 21215-0036 Specify. Black ð 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Jewelry Salesperson 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Unknown) Mary Norris Showell ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20850 10100 Sterling Terrace, Rockville, Md. Morgan E. Death / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 I Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 5/15/09 Alexandria, Va. 21. Signature of Fineral Septice Licensee 22. Name and Address of Facility Muriel H. Barber Funeral Home -00970 Uhb 20882 Lucres P. O. Box 5038, Laytonsville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Failure to Thrive **Physician** Weeks /Medical Due to (or as a consequence of): Examiner Months Cardiomyopathy Sequentially list conditions, any Letting to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Months Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 🗷 No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ₹ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 🛣 No 1 ☐ Yes 2 ☐ No neral after death.

Neral Director: After this certification by the funeral director, illed in by the funeral director, its second of the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 24 hours a 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and the of certifier May 14, 2009 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20850 KB 9901 Medical Center Drive, Rockville, Md. Sujatha Ramaseshan, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State varker MAY 8 Registrar BARBEAN.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ERMA 26, MAY RANKENBERRY /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 12710 Bunting Street Cumberland Allegany Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)

MD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours Month, Day, Mar 6, 1917 1 □ M 2 □ 5 214-10-4702 Director 92 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show r than "natural", or items 23a or 28a-f shov MD Allegany Cumberland 1 □¥es 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 12710 Bunting Street USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married 1 □ Yes 2 □ No Baltimore, Maryland 21215-0036 "natural", or Specify: þ white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) יייט 2 should be filed within lealth and Mental Hygiene. n 27 is marked other than "n. er traumatic event Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Heatth and Menta Important: If item 27 is marked any Injury or other traumatic ev David Griffith Cora Griffith ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11909 Homewood St., Cumberland MD 21502 19a. Informant's Name/Relationship (Type. Print)
Kimberly Llewellyn niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rocky Gap Veterans Cemetery 5/29/2009 MDFlintstone 21. Signature of Funeral Service Ucen ee 22. Name and Address of Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part . Enter the disease or com lic ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only in cause on each line.

Immediate Ca is (Final disease or con in or con Approximate Interval Between Onset and Death **Physician** ,lac /Medical Due to s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) signed by the a d be detached for P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 ☐ Unknown icate has been si , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 □ Yes 2 □ No certificate 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D2337 5-27-2009

State Registrar

DHMH 17 Rev 1/2001

904 SETON DR

32 Registrar's Signature

SUITE 203 CUMBERLAND, MD 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ZAMAN, M.D.

31. Date filed (Month, Day, Year)

			For State		State of M	laryland /		rtment of F tificate of I			Mental Hy	_				- 1 -
			Registrar 1. Decedent's Name (Fi	irst, Middle, Las	st)				Doui		2. Date of D	Reg. No	200	9	3. Time of	Death
	Physici /Medio		JOHN EDWAR	D FLANA	GAN, JR.						Month MAY	12, ^{Da}	2009 Ye	ar	03:30	P . M
**	Examir		4a. Facility Name (If not	_		r)		4b. City, Town, or			h	4c.	County of D			
- Marin	Funeral		TALBOT HOS 5. Social Security Numb			ge (In yrs. last	birthday)	If Under 1 Year	EAST(UN er 24 Hrs.	8. Date of B	irth		LBO'I Birthpla	ace (State o	or Foreign
	Director		216-24-051		M 2□F	80	Yrs.	Months Days	Hours	Min.	8. Date of B (Month, D JUNE 1.	2, Year)	928	MAI	YLANI)
	and		Usual Residence of Dec 10a. State 10	b. County		10c. City, To	own or Loc	ation						10	d. Inside Ci	ity Limits
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	thin 72 hours after death with the Maryland e. an "natural", or items 23a or 28a-f show Mydral Exporter must be rediffed at	Funeral	11. Marital Status1 ☐ Never Married	2X Married	12. Was Deceden Armed Forces 1 X Yes 2 F		_ If	as Decedent of H Yes, specify Cuba	lispanic C an, Mexic	Origin? (S an, Puerl	specify Yes or N to Rican, etc.)	0-	14. Race - A Black, W			
21215-0036	ours af	by	3 ☐ Widowed 4 ☐		If Yes, Give Year or Dates	101	1 1	□Yes 2 X No	Specif	fy:			Specify:	WHI'	Œ	
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Maryland		2	JOHN E. FL	ANAGAN,	SR.				MA	RY G	RACE SPI	JRRII	ER			
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Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funera	- TN			22. CR1	Name and Addre	ss of Fac	ility FE]	LLOWS 1	HELER	CNRETN	ANI	NEWN	MAL
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ord	w require been si should t	ted	Hyperter	5101	, Itypai	14pide	mia				1	Yes 2	□ No 3□] Proba	ably 4	Unknown
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N N	S S	o Be	examiner? 1 ☐ Yes 2 No	to medical	Hospital: 1 ☐ Inpa	tient 2□ER	/Outpatient	3 □ DOA Oth	.o.e:		ath <i>(Check only</i> Home 5 ☐ Re		6₩ÔOther (Specify	Hosi	DICE
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Division	l or Atten after deatl Director:	Certification:	4 ☐ Homicide	determined	20e. Place of f	etc. (Specify)	e, tarm, stre	et, factory, office			28f, Location City or To	(Street a own, Stat	na Number o e)	r Hurai	Houte Nun	nber,
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:	ledical C	29a. Certifier 1 (Check only one) 2	ertifying Ph Medical Exan	ysician: To the bes niner: On the basis and manner:	of examination	dge, death and/or inv	occurred at the ti estigation, in my o	ime, date opinion, d	and plac leath occ	e, and due to thurred at the time	e cause(e, date ar	s) and manne d place, and	er as sta due to	ated. the cause(s	s)
	To the within 2 To the comple	Med		of cartifier				29c. Licens	se numbe	r		29d. Da	ate signed (N	fonth, E	Day, Year)	
	axla	C) (8	da	MD			D3	319	97	-	5	114	12	009	
	1000	٢	30. Name and address	f person who	MD; 26 MD; 26 32 Regis	death (Item 23	Ba) (Type, P	Print)	t. 10	20	Adain	Par	0 14		11/1	,
	Sta	te	31. Date filed (Month, E	Day, Year)	32 Regis	trar's Signature	o cert	ring s.	~ 10	<i>(</i>)	ITIVIV A	OLL	11/1	1 2	170	
	Registr		MAY	15 200	19 /	~ A.	be	N.								
DH	MH 17 Rev 1/2	001			1	-	7									

		For State	State of Ma	-	epartment of		Mental Hy	giene	•	1701
		Registrar		(Pertificate of	Death 		Reg. No	·2009	1/64
ysicia	n	1. Decedent's Name (First, Middle, L	.ast)	6-0.10	1		2. Date of De Month	Da		3. Time of Death
Nedica	al	ANTONIO	FI	FERNA	·	1	05	12	County of Deat	
amine	er	4a. Facility Name (If not institution, g 381 Colony Poin			7.	or Location of Deatl ewater	1	40.		Arundel
eral				e (In yrs. last birtho	(ay) If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	rth		hplace (State or Foreig
ctor		072-16-5132	1 M 2 □ F 87	Yr	s. Months Days	Hours Min.	1/8/1	922	Por	uintry) tugal
		Usual Residence of Decedent		10- City T						10d. Inside City Limit
aumatic event, the Medical Examinat must be notified at	٦	10a. State 10b. County		10c. City, Town o						1 □Yes 2 N
all l	Directo	Maryland Anne A	rundel	Ed	gewater 10f. Zip Code			10× Cit	tizen of What Co	
8	ᄒ	381 Colony Poin	+ Dlace		2103	7		_	USA	unity:
	Funeral	11. Marital Status	12. Was Decedent B	ever in U.S.			pecify Yes or No		14. Race - Ame	rican Indian,
١,	逼	1 ☐ Never Married 2 Married	Armed Forces?		13. Was Decedent of If Yes, specify Cub		o Rican, etc.)		Black, White	
	۵	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1943-46	1 □Yes 2X No	Specify:			Specify:	White
	Completed	15. Decedent's I (Specify only highest g	Education		ecedent's Usual Occu		kina	16b. K	ind of Business/	Industry
8 1	np/du	Elementary/Secondary (0-12)	College (1-4or 5	+)	Give kind of work done fe. DO NOT use retire	daning most of wor	King			
	ပ်		5+ years	T	eacher				ducatio	n
	Be	17. Father's Name (First, Middle, Las	_{st)} ucio Fernan	1		18. Mother's Nar				
_ i	၉					L	Gloria D			
once.		19a. Informant's Name/Relationship		- 1	failing Address (Stree			-		
		Frances M. Ferna 20a. Method of Disposition	ndes/ wire		1 Colony P		Date Luge		ocation - City or	
		1 X Burial 2 ☐ Cremation 3		1	isposition (Name of crematory or other pla	i i				
		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice	* '	Kesurre	ection Ceme		16-09			Maryland
ouce	П	21. Signature by Funeral service Lice	ensee			00				ral Home
		23a. Part 1. Enter the disease, or co	mplications that caused	the death. Do not					ewater,	MD 21037 Approximate
		shock, or heart failure. List onl Immediate Cause (Final	ly one cause on each lir	ie.	-			-	> 1	Interval Between Onset and Death
		disease or condition resulting in death)	a. Due to (or see	a consequence of)		DELY	WEDA	11-5-(110	MONTHS
1			Due to (or as a	a consequence or,	•					
١	Je	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Une to (or es :	a consequence of)	7					
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1.	-	resulting in death) Last	Due to (or as	a consequence of)	:					
	dica		d							
1	Physician/Medica	IF FEMALE:	One House subserve	of			- 50	. 1		
	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal death	3 Ectopic pregnar	су			23d. Date of de Month	livery Day Year
1	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 ☐ Unknown	time or death	5 ☐ Other (specify)					
		Part II. Other significant conditions	s contributing to death bu	ut not resulting in th	ne underlying cause gi	ven in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
	d by						16	Yes 2	□No 3□P	robably 4 Unknov
	lete						24a. Was	an	24b. Were au	utopsy findings availab
	Completed						auto	psy ormed?	prior to death?	completion of cause o
		25. Was case referred to medical				26. Place of Dea	1 Tes	2 No	1 ☐ Yes	s 2 □ No
	o Be	examiner? 1 Yes 2 No	Hospital:	nt 2 ER/Outp	atient 3 DOA Ot	hor			6 ☐ Other (Spe	acifu)
	년 : 1	27. Manner of Death	28a. Date of Inju	ry 28b. Tin	ne of 28c. Inju		28d. Describe			iony)
:	aţio	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigati	(Month, Day	v, Year) Inju		rk?]Yes 2 □No				
3	Ë	3 ☐ Suicide 6 ☐ Could not determine		ry - At home, farm	, street, factory, office		28f. Location (ural Route Number,
10	Certification:	4 - Hermondo	building, etc	, (Opeony)			Only of 10	mi, otal	-,	
		29a. Certifier (Check only (Check only	Physician: To the best of aminer: On the basis of	of my knowledge, of examination and/	death occurred at the	time, date and plac	e, and due to the	e cause(:	s) and manner a	s stated. e to the cause(s)
Ì	edical	one)	and manner sta	ited.						
	2	29b. Signature and title of certifler	Dol +	1.	29c. Licer	se number	,	29d. Da	ate signed (Mont	in, Day, Year)
1	\sim		MININ	m		11111		1	lay 1	1, 2009
4			Λ						-	
The state of the s	i	30. Name and address of person wh	o co p ted cause of d	eath (Item 23a) (Ty	(pe, Print)	CE HI	SHUA	AA	IN APOL	I MAZIKAI
State		30 Name and address of person when the state of the state	o co peted cause of d	eath (Item 23a) (Ty	find CYEN	SE HI	SHWAY	A	IN APOL	2, ZOOJ

			For State Registrar	State of Mar	yland		rtment o				Reg. Ng	09	17649
	Physici	an	1. Decedent's Name (First, Middle, Last							2. Date of Dea	Dav	Yeer	3. Time of Death
	/Medic	al	David Baldwin 4a. Facility Name (If not institution, give				4b. City, Tow	on or Locati	on of Death	MAY	4c_County	2009	1925
-	Examir	er	Dorchester	General	Hos	pita	1 Ca	embr	rid9	e	Dor		ster
	Funeral		5. Social Security Number 6. Se	x 7. Age (st birthday)	If Under 1 Yo Months Da	ear If Un	der 24 Hrs.	8. Date of Birt (Month, Da May 19	h y. Ygar)	9. Birthplac Country Mary	ce (State or Foreign
	Director		214-66-7533 Usual Residence of Decedent]M 2□F	53	Yrs.				May 19	, 1955	Mary.	Land
	ehow		10a. State 10b. County	1	Oc. City,	Town or Loc	cation					10d	. Inside City Limits
V1.	n Maryland a-f ehow	tor	MD Dorches	ster			Ca	ambrid	lge				1 ☐ Yes 2 ☐ No
2	aftar death with the Maryle or Items 23s or 28s-f ehov	Funeral Director	10e. Street and Number	D 3			10f. Zip Coo		12		10g. Citizen of	What Country JSA	1?
23	sath w	Frail	3006 Steamer Rur	1 ROACI 12. Was Decedent Ev	ar in II S	12 W	Vas Decedent	216		ecify Yes or No		ce - American	Indian.
10	ftar de	Fune	11. Marital Status 1 Never Married 20 Married	Armed Forces? 1X∑Yes 2 ☐ No		ĺ				ecify Yes or No Rican, etc.)	į .	ck, White, etc	2.
5-0036	rei', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 1	973	1	☐Yes 2XX	No Spec	oify: 		Specil	y: whit	ce
5-0	72 ho	Completed	15. Decedent's Edi (Specify only highest grad			16a. Deced	ent's Usual Ookind of work do NOT use re	ccupation bne during r	nost of work	ing	16b. Kind of B	usiness/Indu	stry
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and 2	2 should be filad within 72 hours aftar and Mental Hyglana. is marked other then "naturel", or ite aumatic event, the Medical Examina	BeC	17. Father's Name (First, Middle, Last)					18. M	other's Nam	e (First, Middle,	Maiden Sumai	71e)	
- TO	should be and Menta marked umatic ev	To B	Levin Morris Fit	zhugh		• 1				Aaron			
Mary	s 1 and 2 should be filad withlr if Haaith and Mental Hyglana. Item 27 is marked other then other traumatic event, the Mi		19a. Informant's Name/Relationship (T							al Route Numbe		. <i>St</i> ate, <i>Zip C</i> 2161	_
	of Haalth Item 27		Susan K. Fitzhugh 20a. Method of Disposition	wif			Steame of their story or other			Cambrio Date	20c. Location		
Jon J	agas ant of it: If it y or o		1 ☐Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify,		l .		natory or other Veterar		n 5/	18/09	Hurlo	ck, MD	
Baltimore,	permit. Pagas 1 and 3 Dapartmant of Haalth Important: If Item 27 any injury or other tru <u>once.</u>		21. Signature of Funeral Service Licens		1 2	22	. Name and A	ddress of Fa	acility T	homas Fi		Home P	.A.
0			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the	ne deeth.							A	approximate nterval Between
	Physician		Immediate Cause (Final disease or condition	Sale 1	0	920	Cons	ø (es de	omil (Date		Onset and Death
-	/Medical Examiner		resulting in death)	Due to (or as a	conseque	nce of):	0	0	0 3		1	1	
	LXdillillei	-	Sequentially list conditions, if any, leading to immediate	b. Eno	conseque	left	e Ke	nel	De	2000	0	V	
	utad J Insit	Examiner	cause (Disease or injury that initiated events	Dia	2.7	-	M.	Oites				117	
oʻ	a ba exacutad sictan and t burlat-transit		resulting in death) Last	Due to (or as a	conseque	ince of):					-		
8760,	ata ba hysick tha bu	lcal		d									
Вох 68	as that tha daath certifica Igned by tha attanding ph ba datachad for use as tt	Physician/Med	IF FEMALE:	23c. If yes, outcome of	pregnan			-			23d D	ate of delivery	,
Bo	attan attan for us	cian	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live birth 2 4 Pregnant at ti	Fetal	leath 3□	Ectopic pregn Other (specif						ay Year
P.O.	t tha c by tha tachac	hysi	9 Unknown	9□ Unknown — —									
S,	as tha gned ba dat	by P	Part fl. Other significant conditions co	intributing to death but	not result	ting in the ur	nderlying caus	e given in P	art I.				cause of death?
ord	raquir een sl	ted	Comm	ely al	du	1_0	usee	rl_	<u>, </u>	- -	Yes 2 □ No	3 Probab	, <u>\</u>
3ec	a law has b ja 2 st	Completed		V						24a. Was autoperfo	an 24b. psy prmed?	death?	y findings available detion of cause of
<u>a</u>	n: Th ficata or. pag	e Co	25. Was case referred to medical					06 B	Hann of Dogs	1 ☐ Yes	2 10	1 ☐ Yes 2	□ No
<u> </u>	ysicia s carti diracto	To Be	ovaminor?	Hospital: 1 ☐ Inpatient	2 X E	R/Outpatien	t 3□ DOA	Othor	Nursing Ho		dence 6 □Ot	her (Specify)	
Division of Vital Records,	ng Phy Iter thi naral		27. Manger of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year)	8b. Time of Injury	28c.	Injury at Work?		28d. Describe	how injury occu	rred	
Sio	tendii laath. tor: A tha fu	catio	2 Accident investigation 3 Suicide 6 Could not be	00 80(1-1			М	1 ☐ Yes	2 No	29f Location /	Street and Num	her or Rum I	Poute Number
Ö	aftar of Direction by	Certification;	4 Homicide determined	28e. Place of Injury building, etc.	(Specify)	ne, rarm, str	eet, ractory, or	nice		City or To	wn, State)	00, 0, 1,0,0,1	Touto Numbor,
	To the Hospital or Attending Physician: The law raquiras that the death certificate be executed within 24 hours after death. To the Funeral Director: After this cartificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detected for use as the burial-transit	edicai C	29a. Certifier (Check only one) 1/2 Certifying Physical Example 1/2 Medical Example 1/2 (Check only one)	sician. To the best of iner: On the basis of e and manner state	xaminatio	iedge, death on and/or inv	roccurred at the	ne time, dat my opinion,	e and place, death occur	and due to the red at the time,	cause(s) and n date and place	anner as stat , and due to t	he cause(s)
	To the within To the	Me	29b. Signature and title of certifier	1.10			29c. Li	icense numi	ber		29d. Date sign	ed (Month, Da	ay, Year)
			MALLETY,	MU			D	63	32	7	2/1	710	7
			30. Name and address of person who o	A com	ath (Item :	23a) (Type,			CA	A- 10	0 0 0	2.0	110 0111-
CE.	Sta	to	31. Date filed (Month, Day, Year)	32. Registrar	's Signatu	م وا	03 15	yen	Seu	et, C	moud	8 1	MN-46/
	Regist		MAY 18 20	09	1	A. A.	and the						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** May 24. 2.009 Valeri Ann Galsky /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Montgomery Village Health Care Center <u>Gaithersbug</u> 1 Year | If Under 24 Hrs. | Days | Hours | Min. | Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** 1 □ M 2 🗓 F Director August 2. Virginia 218-38-8269
Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the tracilest Every in a round by nothing at 1 ☐ Yes 2X No Director Maryland Gaithersburg Montgomery 10g, Citizen of What Country? 10e. Street and Number United States Funeral 20879 9429 Merust Lane Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after Hygiene. 1 □Yes 2 No If Yes, Give Year or Dates: o. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ₫ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, I was injury or other traumatic event. College (1-4or 5+) Elementary/Secondary (0-12) Commercial Cleaning Entrepregeur 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ <u>Frieda Jacobs</u> Neville Sis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9429 Merust Lane, Gaithersburg, Maryland 20879 Patricia Faucette / Daughter 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery May 28, 2009 Frederick, Maryland 21. Signatule of Funeral Service Licensee Keeney and Basford PA Funeral Home 106 E. Church Street, Frederick, Maryland 21701 Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician a. Squamous Cell Cancer Pharynx/Hypopharynx /Medical Due to (or as a consequence of): **Examiner** b. Hypertension Sequentially list conditions, Examiner e to for as a monsequence of: cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and the burial-trans c. Pneumonia Due to (or as a consequence of): Box 68760. Physician/Medical d <u>Acute Respiratory Failure</u> the attending posterior IF FEMALE: ves, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 🗆 Ectopic pregnancy Day Month Year 1 ☐ Yes 2 No 5 Other (specify) signed by the a P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of autopsy performed certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ▼ No Hospital or Attending Physician: 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🙀 No ပ After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No death. To the Funeral Director: completely filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified D41162 May 27, 2009

31. Date filed (Month, Day, Year) JUN 02 201 Registrar

Vinu Ganti,

M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

19529 Doctor's Drive, Germantown, Maryland 20874

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State of Ma	ryland / [Mental Hy	giene		
			Registrar			Certifica	te of D	eath	Ta a	Reg. No. 2	009	17651
	Physici	an	1. Decedent's Name (First, Middle	•		04			2. Date of De	Day 20	2009	10:00 P M
	/Medic		Lino 4a. Facility Name (If not institution,	Silvio		Gian		ocation of Deatl	May		ounty of Death	
	Examin	er	625 Observator	•			gerst				ashingt	
	Funeral			6. Sex 7. Age	(In yrs. last bir	thday) If Und	er 1 Year	If Under 24 Hrs.	8. Date of Bir	rth	9. Birth	place (State or Foreign
	Director		396-16-1931	1 ⊠ M 2□F	84	Yrs. Months	Days	Hours Min.	Aug. 2	9, ^{year)}		consin
	pu ,		Usual Residence of Decedent		10c. City, Tow	1						10d. Inside City Limits
	aryla shov	5	10a. State 10b. County		- "							1 ☐ Yes 2 🎇 No
	the M	Director	MD Washi	Ington	Hager		ip Code			10g Citizer	n of What Cou	
	with Ba or		625 Observator	r. Defra			1742				U.S.A.	
	ms 2;	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.			panic Origin? (S	Specify Yes or No to Rican, etc.)	D- 14.	. Race - Amer	ican Indian,
9	or ite		1 Never Married 2 Marri	Armed Forces? ed 1 Yes 2 No	0		77	, Mexican, Puert Specify:	to Rican, etc.)		Black, White,	etc.
3	iral",	d by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		TLITES	2 43 140	эреспу.				nite
21215-0036	72 h "natu	Completed	15. Decedent' (Specify only highes	s Education t grade completed)	16a	. Decedent's Us (Give kind of v	ual Occupat ork done du	ion ring most of wor	rking	16b. Kind	of Business/Ir	ndustry
2	within ene.	dmo	Elementary/Secondary (0-12)	College (1-4or 5+		nagement				IIS G	overnme	ant
ק ס	filed Hygid	ပို	17. Father's Name (First, Middle, L		riai	agement			ne (First, Middle			5116
<u>a</u>	ld be lental ked c	To Be	Cesare Giannoni					Lena Sa	abast i ar	ne Gia	nnoni	
Maryland	bs 1 and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hyglene. I them 27 is marked other than "natural", or items 23a or 28a-f show rother traumatic event, the Medical Examinar mat be nothered.	Γ.	19a. Informant's Name/Relationsh	ip (Type. Print)	195	. Mailing Addre	ss (Street an	nd Number or Ro	ural Route Numb	er, City or T	own, State, Z	ip Code)
2	and 2 lealth a m 27 is		Celia Patchett/	Daughter	1	1206 Bri	Larwoo	d St., 1	Marshfie	eld, W	I 5444	9
Baltimore,	of He		20a. Method of Disposition 1 Burial 2 □ Cremation	3 D Ramoval from State	20b. Place o cemete	f Disposition (N ry, crematory or	ame of other place))	Date	20c. Loca	tion - City or T	own, State
Ě	permit. Pages 1 Department of I Important: If ite any Injury or of		4 □ Donation 5 □ Other (Sp	ecify)	Rest H	Haven Ce			/2009		rstown	
a E	permit Depar Impor any In once.		21. Signatur of Funeral Service	flourisee					est Have			-
_	407 60		200 Batt Estate diam's		the death De				Ave., Ha		own, M	D 21742 Approximate
		1 10	23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final	only one cause on each line	e.		one or uying,	, such as cardia	c or respiratory a	arrest,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	novati		cer					2 months
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	cuted nd ransit	Examiner	that initiated events	c.								
Š,	e exe ian al urial-t	Ë	resulting in death) Last	Due to (or as a	a consequence	of):						
8/60	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	dical		d								
٥ ×	ding page as	/Me	IF FEMALE:	23c. If yes, outcome of	of pregnancy							
ğ	atten for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2	2 🗌 Fetal death	n 3 ☐ Ectopio				230	d. Date of deli Month	Day Year
j.	the d	ysi	1 □Yes 2 □No 9 □ Unknown	9 ☐ Unknown		o L o mor (opcony)					
ν. Τ	w requires that the death certifiction is been signed by the attending is should be detached for use as	by Pt	Part II. Other significant conditio	ns contributing to death bu	it not resulting i	n the underlying	cause given	n in Part I.	23e. Did	tobacco use	contribute to	the cause of death?
ecords,	quire en sig uld b	ed b							10	Yes 2□	No 3 □ Pro	obably 4 Unknown
•	- D 70	plet							24a. Was	s an	24b. Were au	topsy findings available ompletion of cause of
r	The ate h page	Completed							perf 1 ☐ Yes	ormed?	death?	2 □No
VITA	clan: sertific setor,	Be (25. Was case referred to medical examiner?						ath (Check only			
0	Physi this c	၉	1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatier 28a. Date of Injur		utpatient 3 ☐ 1 Time of		4 LI Nuising I	Home 5 A Res			cify)
5	ding h. After funer	tion	1 ☑ Natural 5 ☐ Pending	(Month, Day	(Year)	Injury	28c. Injury Work?	es 2∐No	260. Describe	riow injury c	ccurred	
UNISION	Atten deat ctor:	fica	3 ☐ Suicide 6 ☐ Could n	ot be 280 Place of Injur	ry - At home, fa			00 0 0 0 1 1 1			Number or Ru	ral Route Number,
2	al or / s after I Dire	Certification: To	4 ☐ Homicide determi	building, etc.	. (Specify)				City or To	iwn, State)		
	To the Hospital or Attending Physiclan: The law within 24 hours after deads. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 completely filled in by the funeral director, page 2.		(Check only 2 Medical B	g Physician: To the best o Examiner: On the basis of	examination a							
	o the lithin 2 or the omple	Medical	29b. Signature and title of certifies	and manner stat	ted.	2	9c. License	number		29d. Date	signed (Month	ı, Day, Year)
	72		Andrew .				DAGE	C. K. A. C.		8	5/21/	2009
,	12/11	T	30. Name and address of person v	who completed cause of de	eath (Item 23a)	(Type, Print)	1002	0882			1-11/	
	4,		NEAR PATALINGH	46, M,D 11110	mdia	al Carys	ns Ra	1 Sink	107, Aag	erstown	, mn	21742
	Sta		30. Name and address of person of NETT PHALIN SH. 31. Date filed (Month, Day, Year)	32. Rygistra	ar's Signature	house						
	Registr	वा	11111 20 2	- A Company	The second	1630 40 W	-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day Month A^{M} 30 May 15 2009 PATRICIA JOHNSON GLADCHUK 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Frederick Frederick Memorial Hospital Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/14/1926 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Min 1 □ M 2√2 F New York 83 049-14-4618 Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location Yes 2□No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 426 Carroll Parkway 21701 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 XNo Specify: Specify: White 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant College Athletic Dept. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas Beatrice Irving Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Gladchuk / Son 713 Midway Drive, Frederick, Maryland 21701 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 5/16/09 Smithsburg Crematory Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 21. Signature Funeral Service Li NORTH MARKET ST., FREDERICK, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stroke disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner executed

Physician

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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Department of Health and Mental Hygiene. Important; or items 23a or 28a-f show any Injury or other traumatic event, If a Medical Examination traumatic event, If a Medical Examination and Injury or other traumatic event, If a Medical Examination and Injury or other traumatic event, If a Medical Examination and Injury or other traumatic event, If a Medical Examination and Injury or other traumatic event, If a Medical Examination and Injury or other traumatic event, If a Medical Examination and Injury or other traumatic event, If a Medical Examination and Injury or other traumatic event, If a Medical Examination and Injury or other traumatic event, If a Medical Examination and Injury or other traumatic event, If a Medical Examination and Injury or other traumatic event, If a Medical Examination and Injury or other traumatic event, If a Medical Examination and Injury or other traumatic event, If a Medical Examination and Injury or other traumatic event, If a Medical Examination and Injury or other traumatic event, If a Medical Examination and Injury or other traumatic event, If a Medical Examination and Injury or other traumatic event, If a Medical Examination and Injury or other traumatic event, If a Medical Examination and Injury or other events

d 2 should be filed within the and Mental Hygiene.
7 Is marked other than "

Pages 1 and 2 siment of Health an ant: If item 27 is

within 72 hours after death

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

law requires that the death certificate be

/Medical

burial-transi Exami and physician as the burial-Physician/Medical attending ph sate has been signed by the page 2 should be detached þ Completed certificate director, Be Certification: To After this funeral

Hospital

Division of Vital Records, or Attending within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu filled in by

> Pratima Pandey, MD 31. Date filed (Month, Day, Year) State MAY 18 Registrar

Natural 2 Accident

3 ☐ Suicide

29a. Certifier

Medical

4 Homicide

(Check only one)

29b. Signature and title of certifier



and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

1 🗹 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

D64910

5-15-2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

400 West 7th Street, Frederick, Maryland 21701

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

5 ☐ Pending investigation

6 Could not be determined



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 0150 M 05 Holtzman G. <u>June</u> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegan WMHS-Braddock Campus umber land If Under 1 Year | If Under 24 Hrs. 9. Birthplace Country) (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🔀 F 66 Director 05/31/1942 West Virginia 218-38-2712 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Evantimer roust be motified at 1 Yes 2 No Director WV Springfield Hampshire 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 26763 USA HC 65 Box 2830 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 □Yes 2 🕅 No Specify: If Yes, Give Year or Dates: Specify White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Wade once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Guy Roberts Texas ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) HC 65 Box 2830, Springfield, WV Gary Holtzman / Husband 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 05/18/2009 Cumberland Crematory Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Alams Family Funeral Home, P.A. 21. Signa Lr of Funeral Service License 404 Decatur Street, Cumberland, MD 21502 23a. Part t Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final days Physician congestive disease or condition resulting in death) /Medical Due to (or s a consequence of): Examiner andiovascular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions continues to death but not resulting in the underlying cause given in Part I. Completed by erosclerosi 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy HOT tenosi 2 No 1 ☐ Yes 2 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28h Time of 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

The law requires that the death certificate be executed and use as the burial-tra P.O. Box 68760, attending physician for use as the buria signed by the ned by of Vital Records, peen page 2 s certificate director. After this funeral Division Hospital or Attending after death.

Director: Af completely filled in by within 24 hours a

To the Funeral I

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

3 nes 29a. Certifier

29b. Signature and title of certifier

Medical

acce in D 912 Seton

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Rive, Cumberland Maryland 21502

gause of death (Item 23a) (Type, Print) Name and address of person who complete

Year,

Registrar's Signatu

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 7654 1 - For State Registrar Certificate of Death Reg. No. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 17 1515 May 2009 Charlotte Heagy Bright Hollinger /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner Carroll Carroll Hospice Dove House Westminster Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Hours Months 1 □ M 2 🔀 F June 06 1929 79 PΑ Director 212-28-1604 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show traumatic event, the Medical Examiner must be notified at 1 XYes 2 ☐ No Director Westminster Carroll 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9 Apt #228 21158 IISA 23a 1000 Weller Circle Funeral items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 9 1 □Yes 2 □ 🎌 Specify: Specify: ģ 3 Widowed 4 Divorced White "natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) than Elementary/Secondary (0-12) Medical Secretary Medical marked other 18. Mother's Name (First, Middle, Maiden Surname) _ snould be fil. The and Mental Hv 17. Father's Name (First, Middle, Last) Louise Lillian Warehime Leslie Heagy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Apt #228 Westminster, MD 21158 Pages 1 and 2 Health em 27 ls Byron Hollinger/husband 1000 Weller Circle item 27 3altimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If iter any Injury or oth 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Carroll Cremation, Inc 5/21/2009 Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) re of Theral Serv Prittes Funer Fallithome and Chapel, P.A. 412 Washington Road Westminster, MD 21157 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tipe. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** leans /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): attending physician for use as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) signed by the a Ö 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? ut not resulting in the underlying cause given in Part I. Part II. Other significant conditions Division of Vital Records, ≥ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown icate has been siç page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Hospital or Attending Physician: The certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Mother (Specify) HOSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? After 1 (Month, Day, Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year)

NJL 20

9

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of deat

29b. Signature and title of certifier

15 Registrar's Signature

(Item 23a) (Type, Print)

STONER AUC WEST HINST

29c. License number

13

State Registrar BOON POH LIM.

MAY 18

31. Date filed (Month, Day, Year)

M. D.

32. Registrar's Signature

7601 OSLER DRIVE TOWSON, MARYLAND

21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

		-	For State Registrar	State of Marylan		partment of b ertificate of l		•	gierie , Reg. No. (2009	17656
	Physicia	an	Decedent's Name (First, Middle, Las		Las	n		2. Date of Dea		Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give		MATE	DESTY 4b. City. Town, or	Location of Death	<i>U</i> >	4c. C	County of Death	[0 00 m
المحرر	Examin	er	Mandrin Hospice			На	rwood			Anne Aru	
	uneral rector		5. Social Security Number 578-05-6997 Usual Residence of Decedent	M 2□ F 7. Age (In yrs.	last birthd 92 Yrs	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 3/9/19	th 1, Year) 17	9. Birthp Coun Washi	lace (State or Foreign try) ngton, DC
Aaryland	Show	ō	10a. State 10b. County MD Anne Ar		y, Town or Edge	Location Water				10	0d. Inside City Limits 1 □Yes 🛣 No
death with the Maryland	sa or 28a-	Funeral Director	10e. Street and Number 18 Austin DR.			10f. Zip Code	21037	,	10g. Citiz	en of What Coun	try?
ē	r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1XXYes 2 ☐ No WW If Yes, Give Year or Dates:	.s. III	3. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2X No		ecify Yes or No Rican, etc.)		4. Race - Americ Black, White, e Specify: W	
215-0036 thin 72 hours aft e.	"natul edical	Completed	15. Decedent's Ed (Specify only highest gra		16a. Do	ecedent's Usual Occup live kind of work done of e. DO NOT use retired	ation during most of work d)	ing	16b. Kin	nd of Business/Ind	lustry
N D D	er than	Somp	Elementary/Secondary (0-12)	College (1-4or 5+)		ook Binding	3			Publishi	ng
and Z	ed other	Be	17. Father's Name (First, Middle, Last) Bernard Hardesty				18. Mother's Name	- '	, Maiden S	Surname)	
≥ ⊽ €	item 27 is marked other traumatic e	P L	19a. Informant's Name/Relationship (Robert B. Hardest	Type. Print)		ailing Address (Street O Union Chu		al Route Numb	er, City or bury	Town, State, Zip	Code) 04
Saltimore, Normalist Pages 1 and Department of Health	nt: If item ;		20a. Method of Disposition to Survival 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	Place of Dicemetery,	sposition (Name of crematory or other place t Memorial	ce) ¦	Date / 2009		cation - City or To	
Departit	Important: If ite any injury or of		21. Signature of Funeral Source Licer		Į,	22. Name and Addre	ss of Facility Har Ave . An	desty F napolis	unera , MD	al Home, 21401	P.A.
} /M	sician edical ıminer		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	NG	, W	ng, such as cardiac	or respiratory a	in AST	ATIC	Approximate Interval Between Onset and Death
68760, tificate be executed	physician and the burial-transi	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consector) Due to (or as a consector) Due to (or as a consector)							
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P.O.	signed by the a I be detached f	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 🗆 Unknown			ven in Part I.	23e. Did	tobacco u	se contribute to t	he cause of death?
rds,	s been sign should be	ed by						15	Yes 2[□ No 3 □ Pro	bably 4 🗌 Unknown
Rec	8 CI	Completed						24a. Was auto perf 1 ∐Yes		prior to co death?	opsy findings available ompletion of cause of 2 □ No
Vital vician; ⊺	certificate h rector, page	Be	25. Was case referred to medical examiner?	Hospital:		Ott	26. Place of Dea			- MA	NOMIN
O† 9 Phys	this al dii	n: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Tir	ne of 28c. Inju	ry at	ome 5 Res 28d. Describe		Other (Speci y occurred	th)use
DIVISION Of VITA To the Hospital or Attending Physician:	Director: After in by the funer	Certification:	1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	e 28e Place of Injury - At h		M 1 🗆]Yes 2□No		(Street an own, State		al Route Number,
Hospital	Funeral tely filled	Medical Ce	29a. Certifier Certifying P (Check only one) Medical Exa	nysician: To the best of my kr miner: On the basis of examir and mapner stated.	owledge, nation and/	death occurred at the too investigation, in my	ime, date and place opinion, death occu	e, and due to th rred at the time	e cause(s e, date and) and manner as d place, and due t	stated. to the cause(s)
To the	To the comple	3	29b Signature and title of certifier	Rent	16	29c. Licen	se number	438	29d. Dat	te signed (Month,	Day, Year) , 2009
X	B	N	30. Name and address of person who	rateura v	1	ype, Print) 447 DE	FENSE	1+767H	WAY	ANNA	POUS MAZINO,
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAY 14 2	32. legistrar's Sign	nature	pare					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** VIOLA KATHERINE HENRY may 6 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner .lth.vone 8 tti more If Under 1 Year If Under 24 Hrs. 8. Dats of Birth Months Days Hours Min. DEC. 18 9. Birthplace (State or Foreign 7. Age (In yrs. last birthdav) Social Security Number 6. Sex ^{Year)}1920 **Funeral** Months 18°, 1 □ M 2 X 248-26-2275 88 SOUTH CAROLINA Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show or other traumatic event, the Medical Exert for must be notified at 1 XYes 2 No Director MARYLAND HARFORD ABINGDON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code is marked other than "natural", or items 23a or 3641 WOODSDALE ROAD UNITED STATES 21009 by Funeral Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify Specify: BLACK 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BEAUTICIÁN SALON 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any lnjury or other traumatic event once. Be LULA (UNKNOWN) MELVIN THOMAS ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3641 WOODSDALE ROAD, APT. B, ABINGDON, MARYLAND MARY WOODALL / DAUGHTER Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ST JAMES UNITED CEM. 05/23/09 HAVRE DE GRACE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
LISA SCOTT FUNERAL HOME, P.A.
552 LEWIS STREET, HAVRE DE GRACE, MD 21078 21. Signature of Funeral Service Licensee cett-colina 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) /Medical ue to (or as a controlle of): Examiner Ed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consuguence of): execute Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be by Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? burs after death.

eral Director: After this certificate has been sign filled in by the funeral director, page 2 should be 2/No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 16, 2009 MD RE5 - 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

MAY 2 U ZUUY Jenen B. Spark

Sinon

32. Registrar's Signature

PAUN

31. Date filed (Month, Day, Year)

Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2009 May A^{M} 15 8:30 Elaine Carol Heffernan 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Greenbelt 5-C Garden Way If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Min. Days Hours 1 □ M 2 🔀 F Months 75 December 11,1933 River Vale, NJ 142-26-9389 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 X Yes 2 No Maryland Prince George's Greenbelt 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20770 USA 5-C Garden Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 □Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 2 🔀 No 1 ☐Yes 2 X No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Education Bookkeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Paul Heffernan Margaret Egan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Constance McGann / Sister 204 Degraw Avenue, Teaneck, NJ 07666 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crematory 5/16/2009 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 4739 Baltimore Ave. 21. Signature of Funeral Service Licenses Gasch's Funeral Home, P.A. Hyattsville, MD 20781 onston 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Lung Cancer 4 Years Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

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Physician

/Medical

10a. State

Examiner

Funeral

Director

or items 23a or 28a-f show

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Funeral

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Examine burial-trar attending physician for use as the buria Physician/Medical certificate has been signed by the rector, page 2 should be detached ģ after death.

Director: After this certific Be

Completed

Certification: To

Medical

To the Hosp within 24 hor To the Fune completely fi State

Hospital or Attending Physician; The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last 23b. Was decedent pregnant in the past 12 months? □Yes 2⊠No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1∐Yes 2⊠No Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D23600

29d. Date signed (Month, Day, Year)

5/15/2009

30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

Bruce R. Kressel, 5530 Wisconsin Avenue, #1125, Chevy Chase, MD 20815

31. Date filed (Month, Day Ye

29b. Signature and title of pertifier

Registrar

24 hours a filled 14291

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ur W. Hende	1	State of Maryland / Department of Health and Mental Hygic For State Certificate of Death	ene Reg	20	09 176
Physicia dical Examir	n/		Date of Death Month Day 21, 200		3. Time of Death 1608 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Washington Clinton		4c. County of Dear Prince Georg (MM/DD/YYYY) 9. B	ie's
Funeral Director		Months Days Hours Min.	Oct 1, 1	Fore	ign cylland
ryland a-f show any t once.		Usual Residence of Decedent 10a. State	10g	, Citizen of What Co	10d. Inside City Limits 1 Yes 2 X No untry?
death with the Maryland or items 23a or 28a-f show must be notified at once.	Ë	8600 Mike Shapiro 20/35 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify	fy Yes or No-		erican Indian, Black,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Alental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No 3 Widowed 4 X Divorced or Dates: Armed Forces? 1 Yes 2 X No 1 Yes 2 X No specify:		White, etc. Specify: Wh	ite s/Industry
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215-00 be filed wit ntal Hygien rked other ent, the M	Be	17. Father's Name (First, Middle, Last) Arthur Woodrow Henderson, Sr. 18. Mother's Name (First, Middle, Last) Mary Buckle:	er	SATE DOOR HOLD	
MD 21 rd 2 should alth and Me m 27 is man	٩	19a. Informant's Name/Relationship (Type, Print) Denise Crivella— daughter 19b. Mailing Address (Street and Number or Rura 25848 Ricky Drive Hollywood I 20a. Method of Disposition (Name of cemetery, May 23 20)	MD 20636		
imore, Pages 1 ar ment of Her tant: If ite or other tr		1 Burial 2 X Cremation 3 Removal from State A Donation 5 Other Specify:		Alexandria	Virginia
		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch 4405 Broomes Is. Rd. Port 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or re-			Approximate Interv
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Division of Vital Rec To the Hospital or Attending Physician: The within 24 hours after death. To the Finneral Director: After this certificate completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	or Town, S	State)	r Rural Route Number, C
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	2	O.C.M.E.	· · ·	May 22, 2009	
		30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212 31. Date filed (Month, Day, Year)	.01		
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			For State Registrar	State o	of Maryland	•	rtment of F	lealth and N Death		giene 2	009	17660
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	nos		GUPTA, SUNIL, N	1.D., 625			SUITE 10	1, CUMBE	RLAND, M	D 2150	2	
t	Sta Registr	te ar	31. Date filed (Month, Day, Year)	2009 8	Registrar's Signat	ba.	the					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day **Physician** 05/25/2009 9:52 A LAVINIA MAE ELZEY INSLEY /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner CHESAPEAKE WOODS CENTER CAMBRIDGE DORCHESTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🖫 E Yrs. Director 218-16-7331 04/13/1920 MARYLAND Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural; or items 23a or 28a-f show traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 XNo Director MARYLAND DORCHESTER **CAMBRIDGE** the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 104 CHOPTANK TERRACE 21613 USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify 3 X Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 72 h and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) CAFETERIA MANAGER **EDUCATION** 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **OLIN HENSON ELZEY** ဂ္ CECILIA EDNA WALLACE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 si if Health an item 27 is r permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr CAROLYN I. TODD / DAUGHTER 104 CHOPTANK TERRACE, CAMBRIDGE, MD 21613 20a. Method of Disposition 20b Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ■ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 05/28/2009 ST. JOHN'S U.M. CHURCH CEMETERY CHURCH CREEK, MD 21. Signature of Funeral 22. Name and Address of Facility CURRAN-BROMWELL FUNERAL HOME, P.A., 308 HIGH ST., CAMBRIDGE, MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last Due to (or as a Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No be detached 9 Unknown 9 Linknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy certificate 1 ☐ Yes 2 ☐ No 1 Yes To the Hospi al or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 XNo P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After ertification: 1 Natural 5 Pending investigation within 24 hours after death. To the Funeral Director: A 1 🗌 Yes 2 🗆 No ☐ Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certified completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 16,2009 0940 **Physician** Ilyas Roujina Κ. May /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Bethesda Bethesda Naval Medical Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min. Days Hours Months 1 □ M 2 🔀 F 9,1914 Munhall, Pa. 195-01-9453 95 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show ?7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be a ciffied at 1 Yes 2 No Munhall Pa. Allegheny Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 100 21st Avenue 15120 USA death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★No 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
unt: If item 27 Is marked other than "natural", or iter 1 Never Married 2 Married White altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2X No Specify: à 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Medical Clinic Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Meletious Koury Takla Restom ဥ 19a. Informant's Name/Relationship (Type. Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1919 Sunrise Drive Potomac, Maryland 20854 Thomasine Ilyas Alvarez/ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o 1 Burial 2 Cremation 3 XRemoval from State Jefferson Mem.Cem 5/20/2009 Pleasant Hills, Pa 4 ☐ Donation 5 ☐ Other (Specify PATTET PO AD CORTINATOI FUNERAL SERVICE, P.A. Funeral Service Lie 21. Signatur 9241 Columbia Blvd.Silver Spring,Md 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Heart Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Pulmonary Hypertension Sequentially list conditions, any Lating to mm of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): physician s the buria P.O. Box 68760 Physician/Medical attending | for use as If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) ed by the I □Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown chronic obstructive pulmonary disease Completed peen 24b. Were autopsy findings available prior to completion of cause of death? cate has bage 2 s autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Aftert 28c. Injury at Work? 1 🙀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical mpletely (Check only one) and manner stated Vithin 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certification 0101237842 May 16,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bethesda Naval Medical Center Bethesda, Md Erich F. Wedam MD 31. Date filed (Month, Day, Year) 32 Registrar's Signat State 18 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day **Physician** 10:50 PM 9 Robert Lee 2009 Jackson May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1122 Southview Drive Apt. 304 Oxon Hill Prince Georges Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 1939) Jan. 30, 1939 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 ₹M 2 ☐ F 427-74-1353 Mississippi **Director** Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 28a-f show r than "natural", or Items 23a or 28a-f show 1 X Yes 2 ☐ No Director MD Prince Georges Oxon Hill 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1122 Southview Dr. USA Apt. 304 20745 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. other than "natural", or ite 1 □Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Imporant: If Item 27 Is marked other the any injury or other traumatic event, It once. Special Police Private Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be David Jackson Aslena Smith ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9313 Washington Blvd. Lanham, MD 20706 Odell Carter, III/Nephew 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State May 16,2009 Waldorf,MD 4 ☐ Donation 5 ☐ Other (Specify) Heritage Menorial 22. Name and Address of Facility Latney's Funeral Home, Inc 21. Signature of Funeral Service Licensee 3831 Georgia Ave. N.W. WAshington, D.C. 20011 278 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) 2 Months Metastatic Pancreatic Cancer **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 Aresidence 6 ☐ Other (Specify) 2X No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 K Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD35950 May 14, 2009 -MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington, DC 20010 110 Irving St. N.W. Karen Smith 31. Date filed (Month, 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar			rtificate of			R	eg. No.	2009	17664
	Physicia	an	Decedent's Name (First, Middle, Last)						Date of Deat Month	n 18	2009	3. Time of Death 11:05 PM
	/Medic		Connie Marie Johnso 4a. Facility Name (If not institution, give street			4b. City, Town, or	Location		lay		County of Death	11:05 PM
	Examin	er	236 Dr. Jack Road	and number)		Port Do				"	Cecil	
ag til	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last b	rthday)	If Under 1 Year	If Under	24 Hrs. 8.	Date of Birth (Month, Day,	Voar)		place (State or Foreign
ı	Director		192-54-2210 1 □ M 2 Usual Residence of Decedent	2ŽF 48	Yrs.	Months Days	Hours	Min. Ju	1y 4,	1960	0 Penr	isylvania
	land ow		10a. State 10b. County	10c. City, Tov	n or Lo	cation					1	10d. Inside City Limits
	Mary I sh	ţō	Maryland Cecil	Por	t De	posit						1 □ Yes 2 🔀 No
	h the	irec	10e. Street and Number			10f. Zip Code			1	0g. Citiz	zen of What Cour	ntry?
	th wit	a	236 Dr. Jack Road			219	04		U	Jnit	ed State	es
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it of Maried Examine must be notified an once.	by Funeral Director	1 Never Married 2XXMarried 1	as Decedent Ever in U.S. med Forces? ∐Yes 2∭No Yes, Give ear or Dates:		Was Decedent of H If Yes, specify Cuba 1 □Yes 2XNo	lispanic Ori an, Mexicar Specify:		y Yes or No- an, etc.)		14. Race - Ameri Black, White, Specify: Wh	
213-0030	thin 72 hore. Re. Ian "natur. Medical I	Completed	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12)		(Give life.	dent's Usual Occup kind of work done DO NOT use retired	during mos d)	t of working	72		nd of Business/In	
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yland	buld be filed Mental Hygi arked other atic event, II	Be	17. Father's Name (First, Middle, Last) Fred Bobbitt					rs Name (r rl Bol	irst, Middle, I t	waiden i	Surname)	
	should be ind Mental marked c	ဥ	19a, Informant's Name/Relationship (Type, P.	rint) 19	b. Mailir	ng Address (Street				r, City oi	r Town, State, Zi	p Code)
Z Z	nd 2 shou alth and N 27 Is mai r trauma'		James J. Johnson / Sp			r. Jack						
saitimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other tra once.		20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)	val from State 20b. Place cemet		e cremato	- ;	Date 2009			cation - City or To	
	mit. F portan ortan Injur		21. Sign tre of Family all Service Locate	#		2. Name and Addre					_	
ñ	Der Imp any	0.3	Ment el		12	7 South	Main	Street	, Nort	th E	ast, Mar	yland21901
ě,	Physician	Y Y	23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one call Immediate Cause (Final disease or condition	ns that caused the death. Do use on each line. Metustatic	-	ter the mode of dyi	2		espiratory ari	rest,	1	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence								
	cuted of	Examiner	Sequentially list conditions, If any Letin It. annual at a cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to for as a consequence	e of):							
68/60,	tificate be executed ig physician and as the burial-transit		resulting in death) Last	Due to (or as a consequence	e of):							
	rtifica ng ph as th	fedical	IC CENALC.								=	
C. Box	e law requires that the death cer has been signed by the attendin ie 2 should be detached for use	Physician/M	in the past 12 months?	yes, outcome of pregnancy □ Live birth 2 □ Fetal dea □ Pregnant at time of death □ Unknown		☐ Ectopic pregnand ☐ Other (specify) _	су				23d. Date of deli Month	very Day Year
<u>.</u>	that the		Part II. Other significant conditions contribu	ting to death but not resulting	in the u	nderlying cause gi	en in Part	١.	23e. Did to	bacco u	ise contribute to	the cause of death?
	requires been sign	ed by					_		1 □ Y	'es 2[∃NO 3□ Pro	obably 4 Unknown
ecord	law rei as bee 2 shoi	Completed							24a. Was a		24b. Were aut	topsy findings available ompletion of cause of
r	sician; The Is certificate ha irector, page 2	E O							perfor	rmed?	death?	2 4No
	iant ertifica ctor, p	Be C	25. Was case referred to medical examiner?						Check only o	ne)		
=	Je sign	2	1 Yes 2 → Hospi	1 ☐ Inpatient 2 ☐ ER/0		nt 3 □ DOA Ot	ner: 4 □ N				6 □Other (Spec	cify)
ono	tending Physician; leath. tor: After this certific the funeral director,	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	Ba. Date of Injury (Month, Day, Year)	. Time o	Wo	ryat rk?]Yes 2□		d. Describe h	now injur	y occurred	
DIVISION	al or Atte after dea Directo	Certification:	3 Suicide 6 Could not be determined	Be. Place of Injury - At home, building, etc. (Specify)	farm, st	reet, factory, office		28	f. Location (S City or Tow			ral Route Number,
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After completely filled in by the funera	Medical C	(Check only 2 Medical Examiner:	n: To the best of my knowled On the basis of examination and manner stated.	ge, dea and/or i	th occurred at the t nvestigation, in my	ime, date a opinion, de	and place, ar	nd due to the I at the time,	cause(s date and) and manner as d place, and due	stated. to the cause(s)
	Vithir To th сопр	Me	29b. Signature and title of certifier	100	1	29c. Licen	se number			29d. Da	te signed (Month	n, Day, Year)
			> 81/auton Ho	Sail Dig	fol	D00	356	53		5/1	19/05	
			30. Name and address of person who comple	1		, Print)						1 101001
	5		Dr. Martha Hosford-Sk		Wes	t High St	reet	Suit	e 104,	E1k	kton, Ma	ry1and21921
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature								

Registrar

MAY 20 2009 Jenus B. park

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State	of Ma	ryland / D		rtmen <i>tificat</i> e			and M		giene Reg. No.2	09	17665
	(40)		Decedent's Name (First, Middle,	Last)								2. Date of Dea		Year	3. Time of Death
	Physicia			Sandra	Α.	Kosinsk	i					Month May	23	2009	0530 A M
4,000	/Medic Examin		4a. Facility Name (If not institution,	give street and no	ımber)			4b. City,	Town, or	Location o	f Death	-	4c. Cour	ty of Dea	ath
			22 Hickory Lane	9				E1	kton					cil_	
	Funeral			3. Sex 1 ☐ M 2 💢 F		(In yrs. last birtl	nday) 'rs.	If Under Months	1 Year Days	If Under 2 Hours	Min	8. Date of Birth (Month, Day	h y, Year)	C	rthplace (State or Foreign ountry)
	Director		216-62-6843 Usual Residence of Decedent		51		13.					June 16	, 195/	P	Maryland
	and and		10a. State 10b. County			10c. City, Town	or Loc	ation							10d. Inside City Limits
	Mary -fsh	į	Maryland Ceci	1		E1kt	on								1 X Yes 2 □ No
	r 28a	Director	10e. Street and Number					10f. Zip	Code				10g. Citizen o	of What C	ountry?
	23a o	al D	22 Hickory Lane	9				2	1921						States
	ems	Funeral	11. Marital Status	12. Was Dec Armed F		ver in U.S.	13. V	Vas Deced Yes, spec	ent of Hi	spanic Ori n, Mexican	gin? (Sp ı, Puerto	ecify Yes or No- Rican, etc.)		ace - Am lack, Whi	erican Indian, te, etc.
20	or it		1 ☐ Never Married 2 ☐ Marrie	I If Yes, G	iive 11	0	1	□Yes	2 X No	Specify:			Spec	cify:	hite
-003	tural'	ed b	3 Widowed 4 □ Divorced 15. Decedent	Year or	Dates:	1 16a.	Deced	lent's Usua	al Occupa	ation			16b. Kind of		
<u>.</u>	in 72 n "na n "na	plet	(Specify only highest	grade completed			(Give I	kind of wo OO NOT us	rk done d	luring most	t of work	ing	Uni	ted	States
7 7	r tha	Completed by	Elementary/Secondary (0-12)	College	(1-401 51	-)	Mai	1 Pr	oces	sor			Pos	tal_	Service
<u> </u>	e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle, L	ast)								e (First, Middle,		ame)	
<u>a</u>	wuld b Ment arked atic e	P P	Arthur Jones									n Jordo	-		-
Maryland	2 sho and is mi	l li	19a. Informant's Name/Relationsh			100						al Route Numb		_	Zip Code)
e) S	and fealth im 27 her to		Kathy L. Coffin	/Sister		20h Blogg of	Dieno	eltion (Mar	ne of			ton, MD			or Town, State
כ כ	tiges 1 In it of 1 In ite		20a. Method of Disposition 1 ፟ Burial 2 ☐ Cremation		n State	Gi Ipin	y, cren Ma	natory or c	ther place	e) ¦	May	27,			
Бапттог	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Inimportant: I fited and Mental Hygiene. Immortant: I fited at 18 marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examinat nature in citied at once.		4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service L			Memori	22	Name ar	ad Addres	ss of Facilit	2009			ton,	עויין
n D	Depa Impo any l		21, Signature of Furieral Service L	0 4 .	1		H	icks	Home	for	Fune	erals, l reet, E	P.A. lkton.	MD	21921
			23a. Part 1. Enter the disease, or	complications that	caused	the death. Do r									Approximate Interval Between
· [hysician		shock, or heart failure. List of Immediate Cause (Final	only one cause on	each	in Co	M	י מסי							Onset and Death
3	/Medical		disease or condition resulting in death)	a. Due to	o (or as	a con equence o	of):	~~							WITSTOOD
	Examiner		Sequentially list conditions	b											
6	p #	iner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury	Due to	o (or as a	a consequence o	of):								
D	xecut and I-tran	Examine	that initiated events resulting in death) Last	c	o (or as a	a consequence (of):								
8760,	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical E			,	·	,								
289	ificate j phys is the	edic		u											
Вох	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant			of pregnancy 2 □ Fetal death	3 [∃Ectopic _I	oregn añ c	v			23d.	Date of o	
ň	death	icia	in the past 12 menths? 1 □ Yes 2 □ No		egnant at	time of death		Other (s		,				Month	Day Year
О	at the by th tache	hys	9 🗆 Unknown									nan Did	lahasas uga s	ontributo	to the cause of death?
s,	w requires that the de been signed by the should be detached	þ	Part II. Other significant condition	ns contributing to	death bu	ut not resulting ir	the u	nderlying	cause give	en in Part i	I.		•		Probably 4 Unknown
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၁	e law has b je 2 st	nple	•									24a. Was		1b. Were prior t death	autopsy findings available to completion of cause of ?
<u>=</u>	iician: The I certificate ha rector, page											1 □ Yes	2 2 No	1 □ Y	
Division of Vital	sician certif rector	Be	25. Was case referred to medical examiner?	Hospital:	71	0 T 5D/0			Oth			th <i>(Check only o</i> ome 5 ⊈ Res		Other (C	naciful
ō	Phys rrthis aral di	Ę	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Da	te of Inju	ent 2 ☐ ER/Ou ry 28b.	Time o		28c. Injur	y at	iursing H	28d. Describe			респу
o	ding th: : Afte	tio	1 Natural 5 Pending 2 Accident investig	9	onth, Da	y, Year) I	njury	М	Worl	k? Yes 2□]No				
N	Atter	iffica	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	20e, Fla	ce of Inju	ury - At home, fa	rm, sti	eet, factor	y, office			28f. Location ((Street and Ni wn, State)	umber or	Rural Route Number,
	tal or Attendii rs after death. al Director: A led in by the fu	Certification: To		91							10				
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director, p.		(Check only 2 Medical	g Physician: To t Examiner: On the	basis o	f examination ar	e, deat nd/or in	th occurre ovestigation	d at the ti n, in my o	me, date a opinion, de	and place ath occu	e, and due to the irred at the time	e cause(s) an , date and pla	d manne ice, and c	r as stated. due to the cause(s)
	the I	Medical	one) 29b. Signature and title of certifie	and m	anner sta	ated.				se number					onth, Day, Year)
	5 × 5 0 0	-		ereficle	1.5	MA					37.7	>			2009.
	^		30, Name and address of person	-		leath (Item 23a)	(Type	Print)	- 00		,				
	10		S.S Sachder	· MD	10	11 1=		à6	ST,	Ell	2 Con	MD 21	921.		
		ate	31. Date filed (Month, Day, Year)	32	. Registr	ar's Signature	A COL								
	Regist	rar	111N (1 9 20 N	1 / Bearing		AND THE PERSON NAMED IN	G 45								

			For State	State of Ma	ryland /						711114	17666
			Registrar			Cer	tificate of L	Jeath 		Reg. No.		
	Physicia	an	Decedent's Name (First, Middle, Las	•					2. Date of De Month	Day	Year	3. Time of Death
	/Medic		John	Gustave			Kunis, Sr		May 1			9:50 P ^M
	Examin	er	4a. Facility Name (If not institution, give					Location of Death		4c. 0	County of Deat	
e F			New Hope Assis		(1	- !- t - a \		erland	O Data of Bir	rth	Alleg	hplace (State or Foreign
	Funeral		5. Social Security Number 6. Security Number 11	X M 2□ F 7. Age	(In yrs. last L Q	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da		Co	untry)
	Director		Usual Residence of Decedent	1	J				03/26/	1929	rei	nsylvania
	land ow		10a. State 10b. County		10c. City, To	wn or Lo	cation					10d. Inside City Limits
	Mary Fresh	to	MD Alle	gany		Cum	berland					1 X Yes 2 □ No
	r 28a	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Co	untry?
	h with		707 Virginia	Avenue			2	1502			USA	
	hours after death with the Maryland tural", or items 23a or 28a-f show at Examinar must be notified at	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S.	13. V	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No	o- 1	4. Race - Ame Black, White	
9	or ite		1 ☐ Never Married 2 ☐ Married	1 1X Yes 2 □ No If Yes, Give	1946	<u>. </u>	☐Yes 2 ☑ No	Specify:			Specify:	White
	ural",	d by	3 X Widowed 4 □ Divorced	Year or Dates:	1948	3						
5	"nat	Completed	15. Decedent's Ed (Specify only highest grad	ucation de <i>completed)</i>	16	(Give	lent's Usual Occup: kind of work done o DO NOT use retired	luring most of work	ing	160. Kin	nd of Business/	Industry
12	withir ene. than	Ę.	Elementary/Secondary (0-12)	College (1-4or 5+)	me. L		,			Manaic	dno1
Maryland 21215-0036	filed Hygi ther		17. Father's Name (First, Middle, Last)				Laborer	18. Mother's Nam	e (First, Middle	, Maiden S	Munic Surname)	That
an	2 should be filed within 72 n and Mental Hygiene. Is marked other than "nat raumatic event, the Medic	To Be		tave	Kun	nis		Nondis	I			Miller
ž	shoul nd M mari	F	19a. Informant's Name/Relationship (7	Type. Print)	11	9b. Mailin	g Address (Street			oer, City or	Town, State, 2	Zip Code)
	and 2 sealth a n 27 is		John G. Kunis, J	r. / Son			oward Str					
ନ୍	~ I 9 #	1 3	20a. Method of Disposition		20b. Place	of Dispo	sition (Name of natory or other plac	6)	Date	20c. Loc	cation - City or	Town, State
Ë	Pages nent of int: If Its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		1		nd Cremat		5/2009	Cum	berland	i, MD
Baltimore,	permit. Pages Department of Important: If II any injury or once.		21. Signature of Funeral Service/Licen		,							Home, P.A.
m	B I Del		HOUSE OKIN	bers		4	04 Decati	ır Street	, Cumbe	erlan	d, MD	21502
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	plications that caused to	the death. D	o not ent	er the mode of dyin	g, such as cardiac	or respiratory	arrest,		Approximate Interval Between
4	Physician	Ϋ́	Immediate Cause (Final disease or condition	, Liver								Onset and Death
1	/Medical		resulting in death)	Due to (or as a								
	Examiner		Sequentially list conditions,	b								
	ed sit	in	if any, leading to immediate cause. Enter Underlying Cause (Disease or hijury that initiated events	Due to (or as a	consequenc	e of):						
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8760,	icate be executed physician and the burial-transit				,	, .						
687		ğ		.d								
	leath certifii attending p	Š	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of						, 2	23d. Date of de	livery
. Box	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	Physician/Medical	in the past 12 months? 1 □Yes 2 □No	1 ☐ Live birth 2 4 ☐ Pregnant at			Ectopic pregnanc Other (specify)	<i>y</i>			Month	Day Year
О	at the de by the a tached	hysi	9 Unknown	9 Unknown								
	s that gned e det	by P	Part II. Other significant conditions of	ontributing to death but	t n ot resulting	g in the u	nderlying cause give	en in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
ğ	w requires s been sign should be	edt							1 🗆	Yes 2]No 3∏P	robably 4 🔀 Unknown
Vital Records,	e law requ has been je 2 shouli	Completed							24a. Was	s an opsy	24b. Were a	utopsy findings available completion of cause of
ž	The I	E							perf	ormed?	death?	s 2 No
<u>ra</u>	sictan: The certificate h rector, page	Be C	25. Was case referred to medical examiner?					26. Place of Dea				
>	Physic this ce	To E	1 Yes 2 X No	Hospital: 1 ☐ Inpatier	nt 2 🗆 ER/	Outpatier	nt 3 DOA Oth	er: 4 ☐ Nursing H	ome 5 ☐ Res	sidence 6	S 🕅 Other (Spe	Assisted Poity) Living
0	ding Ph h. After th funeral	ü	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	y 28t Year)	o. Time of Injury	Worl		28d. Describe	how injury	y occurred	
Sio	tendi eath. or: A	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be					Yes 2□No				
Division of	or At fiter d Direct in by	Certification:	4 Homicide determined	28e. Place of Injui building, etc.	ry - At home, . (Spec <i>ify)</i>	, farm, str	eet, factory, office			(Street and wn, State)		ural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying Ph	ysician: To the best o	f my knowler	dge. deat	h occurred at the ti	ne, date and place	e, and due to th	e cause(s)	and manner a	s stated.
	24 hos 24 hos Fun etely	Medical	(Check only 2 Medical Examone)	niner: On the basis of and manner stat	examination	and/or in	vestigation, in my o	pinion, death occu	rred at the time	e, date and	place, and du	e to the cause(s)
	To th To th comp	Me	29b. Signature and the of certifier			, ,	29c. Licens				e signed (Mon	
1	2+		1 Buly	Who.	en		Mr)	D0054411		May	14, 20	009
			30. Name and address of person who	completed cause of de	eath (Item 23	a) (Type,	Print)					
	MAS		Beverly Cal				norial Av	enue, Cur	mberlan	d, MD	2150	2
	Sta Registr		31. Date filed (Marth Day, Year) 2009	32. Registra	rs Signature	bar	Les .					
	ilegisti	C41		1	1 9	4						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Anita 6:00 Kathleen Knott May 13, 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany Golden Living Center Cumberland If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months 1 □ M 2 🙀 F 86 Maryland Director 218-12-5306 11/18/1922 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show 27 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Expretent in ust be notified at 1 ☑ Yes 2 ☐ No Director MD Allegany Cumberland 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code with t 1534 D Oldtowne Manor Apts 21502 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give^A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 👿 No Specify Specify: <u>Ş</u> 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 Secretary Union 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) is marked oth Be Wilson Gertrude Metzger James Herbert ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other trau once. 12916 Irene Drive, Cumberland, MD Sandra Twigg / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/15/2009 Luke's Cemetery Cumberland, MD 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signatur of Funeral Service 21502 Cumberland, MD 404 Decatur Street. Approximate Interval Between Onset and Death 23a. Part h Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Many on disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an his certificate has bil director, page 2 st autopsy performe 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

P.O. Box 68760, Division of Vital Records, nours after death.

neral Director: After this
filled in by the funeral d within 24 hours a

To the Funeral C

completely filled

> 5 MRS State

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

924 Seton Drive, Cumberland, MD Vikramaditya Poonai, M.D., 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D36766

29d. Date signed (Month, Day, Year)

May 13, 2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** <u>6:</u>15₽ ^M 10 2009 MAY HOMER MARLING KENNELL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ALLEGANY CUMBERLAND DEVLIN MANOR If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex 5, Social Security Number **Funeral** 17€ M 2□F 8-29-1922 PA 86 Director 216-18-1324 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
and: If item 27 is marked other than "natural; or Items 23a or 28a-1 show up or other than the notified at ury or other traumatic event, the Medical Examiner must be notified at 1 TYes 2 No Director CUMBERLAND MD ALLEGANY 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number USA 21505 10301 Christie RD NE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2♥ No If Yes, Give Black, White, etc. 1 Never Married 2 Married Specify: White Maryland 21215-0036 þ 3√ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cement Company Laborer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Erma Edna Lepley Hobart James Kennell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8C 86 Box 131 Ft. Ashby WV 26719 Lynn Kennell/ Son Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 ∑Burial 2 ☐ Cremation 3 ∑ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 5-7-2009 Hyndman PA Porter Cemetery 22. Name and Address of Facility Harvey H. Zeigler Funeral 21. Signature of Funeral Service Licens Home Inc 169 Clarence St Hyndman PA 15545 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure/List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Obstructor Pulminon **Physician** /Medical **Examiner** figurentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. attending physician for use as the buria 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 23a Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 2 - NO certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other:

Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: 5 Pending 1 Matural 1 Yes 2 No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗍 Suicide 4 Homicide Lactifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0017565 5/000 Reivi who completed cause of death (Item 23a) (Type, Print) La Vale ND 911 Neti AJBULINO 120 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 20 2009 Registrar

		ļ	For State Registrar		f Marylar	nd / Depa		t of H	lealth	and M		giene 2	009	17669
	Physicia	an	1. Decedent's Name (First, Middle Elizabeth	e, Last) n Gelman K	OSSOM						2. Date of Do Month May	-	20 ⁶ 6	3. Time of Death 1:30 A. M
1	/Medic Examin		4a. Facility Name (If not institution				4b. City.	Town, or	r Location	of Death	Пау		nty of Death	
	Lxaiiiii	E	Hebrew Home of	_		gton	,		ille				ontgo	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under Months	1 Year Days	If Under	r 24 Hrs. Min.	8. Date of Bi	rth lay, Year) 0, 1913	9. Birth	place (State or Foreign
	Director		578-50-5911 Usual Residence of Decedent	1□ M 2 X □ F	9.	5 Yrs.		24,0	110010	.,,,,,,,	Dec. 3	0, 1913	Was	h." D. C.
DCS	land ow		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits
Acra	Mary a-f sh	tor	D. C.	None	W	ashing	ton							1∭Yes 2□No
18 110	or 28	Dire	10e. Street and Number				10f. Zip		007			10g. Citizen o		-
	s 23a	sral	3718 Calvert St						007				. S.	
//5/64 5-0036	Irs a	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marr 3 □ Widowed 4 ☒ Divorced	Armed Fo	2.X∑No ∕e	1	Was Deced If Yes, spec 1 □ Yes 2	37	ispanic Oi an, Mexica Specify		ecify Yes or N Rican, etc.)	0- 14. F B	ace - Ameri lack, White, cify: Wh	
5/15/64 15-003	72 hc "natu	etec	15. Decedent (Specify only highes	's Education at grade completed)		16a. Dece (Give	dent's Usua kind of wor DO NOT us	al Occupa k done d	ation during mos	st of worki	ng	16b. Kind of	Business/Ir	dustry
ر 121	within ene.	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+) ears		DO NOT us nemake		1)			Ovar	n Home	٠
.^∧. nd 21	filed Hygid		17. Father's Name (First, Middle,		ears	Hon	lemake	: <u>r</u>	18. Moth	ner's Name	(First, Middle	e, Maiden Surn		
A	Ald be Alental rked of tic even	To Be	Elias Gelman	,							Haves		,	
∶⊉∪ A_M , Maryland	permit. Pages 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "n any Injury or other traumatic event, If I Me II once.		19a. Informant's Name/Relationsh John G. Kossov	, , ,								ber, City or Tov Marylar		
ර ර ර – Baltimore,	of He		20a. Method of Disposition 1 → Burial 2 ☐ Cremation	2 Namoval from I	20b. F	Place of Dispo	sition (Nam	ne of ther plac	e)	С	ate	20c. Locatio	n - City or To	own, State
E C	Pag tment tant:		4 □ Donation 5 □ Other (S _I	pecify)	Na Na	emetery, crer ev Sho tional				5-17-				, D. C.
Bal	permit Depar Impor any In once.		21. Signature of Funeral Service	Dtottler	# www	564 D	2. Name an anzan 170 R	^{d Addres} Sky− ockv	GoId ille	berg Pike	Memori , Rock	al Chap v i lle,	els, maryl	Inc. and 20852
	Physician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a	ayed the deat ach line.	ne	er the mod	104	ia	_		arrest,		Approximate Interval Between Onset and Death
55	ate be	ical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b Due to (or as a conseq	uence of):	Lin	- (3 a	đe,	<u>ia</u>			
CTH 60. Box 6	the death certifi by the attending a ached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant, in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		oirth 2 🗌 Feta nant at time of c	Ideath 3	Ectopic pi		/				Date of delive	very Day Year
ZA/	tuires that n signed I	ρ	Part II. Other significant conditio	ns contributing to de	eath but not res	ulting in the u	nderlying ca	ause give	en in Part I	l.				the cause of death?
/ /	The law recate has bee page 2 shoot	Completed								-	24a. Was auto perfe 1 □ Yes	psy ormed?	o. Were auto prior to co death? 1 □ Yes	opsy findings available ompletion of cause of
Vital	clan: sertific setor,	Be (25. Was case referred to friedical examiner?							e of Death	(Check only			
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u	ding I h. After funer	tion	27. Manner of Death UNatural 5 ☐ Pending 2 ☐ Accident investig	,	h, Day, Year)	28b. Time of Injury	M 2	Bc. Injury Work	yat ? Yes 2□		28d. Describe	how injury occ	urred	
Division of	I or Atten after deatl Director: I in by the	Certification: To	2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place	of Injury - At hong, etc. (Specif	ome, farm, stro			res Z			Street and Nui wn, State)	mber or Run	al Route Number,
`	9 Hospita 24 hours e Funeral letely filled	Medical C	29a. Certifier (Check only one) Certifying 2 Medical F	Physician: To the examiner: On the ba	best of my kno asis of examina per stated.	wledge, deatl tion and/or in	occurred a	at the tin in my op	ne, date a pinion, dea	and place, ath occurr	and due to the ed at the time	e cause(s) and , date and plac	manner as e, and due t	stated. to the cause(s)
	Vithin Complete	Me	29b. Signature and title of certifier	2 Sale	012	rio.	29c.	License	number	08	4	29d. Date sign	ned (Month,	Day, Year) 2009
	10	-	30. Name and address of person v	tho completed cause		/23a) (Type,	Print)	NTO	£55.	20	Par	ek inth	e M	920852
	Stat Registra	·	31. Date filed (Month, Day, Year)	2009 Per	egistrar's Signa		Ked.	1/0	- 0	/	/ -		7	
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			For State Registrar	State of	of Marylar	-		of Health of Deat			jiene _{eg. No.} 2	009	17	670
			Decedent's Name (First, Middle	le, Last)						2. Date of Dea	th		3. Time of E	Death
	Physicia /Medic		Miriam K. Katz							05 ^{Month}	13°	09°	12:24	a™
	Examin		4a. Facility Name (If not institutio	-	umber)			wn, or Locatio	n of Death			nty of Death		
1.0			Kline Hospice H	House			Frede		100			erick		
H	Funeral Director		5. Social Security Number 173–12–2121	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs. 88	last birthday) Yrs.	If Under 1	Year If Und Days Hours	ler 24 Hrs. s Min.	8. Date of Birth (Month, Day 05/11/	Year)	9. Birthp Coun Pitts	lace (State or lfry) burgh,	Foreign PA
			Usual Residence of Decedent							03/11/				
H	ylanc how		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					1	0d. Inside City	
/	a-f s	cto	MD Montg	gomery	S	ilver	Spring						1 XYes	2 No
	or 28	Director	10e. Street and Number				10f. Zip Co				•	of What Cour		
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	er de items	Funeral	11. Marital Status	Armed F	cedent Ever in U orces? 277 No	l.S. 13. V	Vas Deceder f Yes, specify	t of Hispanic Cuban, Mexic	Origin? (Spo can, Puerto	ecify Yes or No- Rican, etc.)	14. F	Race - Americ Black, White, e	an indian, etc.	
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ŏ	2 hou	ted	15. Deceder	nt's Education		16a. Deced	dent's Usual (Occupation			16b. Kind o	Business/Inc	dustry	
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Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Heath and Menta Important: If item 27 is marked any Injury or other traumatic ev once.		19a. Informant's Name/Relations Neil Katz	ship (<i>Type. Print)</i> Son				Clover		al Route Numbe Rockvil			Code)	
Baltimore,	f Hea		20a. Method of Disposition		20b.	Place of Dispo cemetery, cren	sition (Name	of	. [Date	20c. Location	on - City or To	wn, State	
9	Pages ent o nt: If i		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		i State I	cemetery, cren I udean]			5/18	3/09	01ney	, MD		
<u>≡</u>	mit. I partm portal / Inju		21. Signature of Funeral Service			22	. Name and	Address of Fa	cility Edw	ard Sag	el Fun	eral D	irecti	on
ñ	a E a			Mo	1163	10	91 Roc	ckville	Pike	, Rockv	ille M	D 2085	2	Inc.
			23a. Part 1. Enter the disease, o shock, or heart failure. Lis	r complications that t only one cause on	caused the dear	th. Do not ent	er the mode	of dying, such	as cardiac	or respiratory ar	rest,		Approximate Interval Bety	veen
1	Physician		Immediate Cause (Final disease or condition		nced Dem	nentia	with f	ailure	to th	hrive			Onset and D	eatn
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89	ntifica ng ph as th	/edi	IS SCHALE.								120			
Вох	eath certific attending p for use as	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		utcome of pregn		Ectopic pre	gnancy			23d.	Date of deliv	*	'ear
0	ie dea the at ned fo	Physician/Me	1 ☐ Yes 2 🔀 No 9 ☐ Unknown	4 □ Pre 9 □ Unk	gnant at time of known	death 5	Other (spec	cify)				WOTH	Day	Cai
Ф.	hat the		Part II. Other significant condit	ions contributing to	death but not res	sulting in the u	nderlying cau	se given in Pa	art I.	23e. Did to	bacco use o	ontribute to t	he cause of de	eath?
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>	ysician: is certific director, I	To B	examiner? 1 ☐ Yes 2 🎛 No	Hospital:	Inpatient 2	BR/Outpatier	nt 3 DOA			ome 5 Resid		Other (Speci	fy) Hoan:	00
0	ding Phys h. After this funeral dii	T:u	27. Manner of Death	28a. Dat	e of Injury onth, Day, Year)	28b. Time o	f 280	c. Injury at Work?		28d. Describe h	ow injury oc	curred	TOSOT	ce-
0	Attendir death. ctor: Af y the fu	atic	Z L Acoldent	tigation	, , , , , , , , , , , , , , , , , , , ,		М	1 □Yes 2	No					
Division of Vital	I or Attenc after death Director: J in by the	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	mined 28e. Plac	ce of Injury - At h ding, etc. <i>(Sp</i> ec	nome, farm, str ify)	eet, factory, c	office		28f. Location (5 City or Tov	Street and Ni vn, State)	umber or Run	al Route Num	ber,
	spital o		29a. Certifier 1 🔀 Certify	ing Physician: To the	no best of my kn	nowledge deat	h occurred at	t the time, date	o and place	and due to the	cause(s) an	d manner as	stated	
	Ho Fur tely	Medical		i Examiner: On the)
	To the Hos within 24 h To the Fun completely	Me	29b. Signature and title of certific	er ,	. 11		29c. l	License numb	er		29d. Date si	gned (Month,	Day, Year)	
	10		Cellen	1 Kei	elles	MIL	ノ D5	4749			May	15 200	9	
			30. Name and address of person		//					0				
					Coll Hou		, D-1,	Frede	rick N	4D 21701				
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1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 27. Manner of Death 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Notural 2 No 28a. Date of Injury M 1 Yes 2 No 28b. Direct of Injury M 1 Yes 2 No 28b. Direct of Injury M 1 Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 28c. Injury at Work? 28d. Describe how injury occurred 28c. Injury at Work? 28d. Describe how injury occurred 28c. Injury at Work? 28d. Describe how injury occurred 28c. Injury at Work? 28d. Describe how injury occurred 28c. Injury at Work? 28d. Describe how injury occurred 28c. Injury at Work? 28d. Describe how injury occurred 28c. Injury at Work? 28d. Describe how injury occurred 28c. Injury at Work? 28d. Describe how injury occurred 28c. Carlifer 2 Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 28c. Injury at Work? 28d. Describe how injury occurred 28c. Injury at Work? 28d. Describe how injury occurred 28c. Injury at Work? 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury at 28d. Describe how injury occurred 28d. Describe how injury at 28d. Describe how injury at 28d. Describe how injury occurred 28d. Describe how injury at 28d. Describe how injury at 28d. Describe how injury occurred 28d. Describe how injury at 28d. Describe how injury at 28d. Describe how injury at 28d. Describe how injury at 28d. Describe how injury at 28d. Describe how injury at 28d. Describe how injury at 28d. Describe how injury at 28d. Describe how	o	the d	ıysi	1 Lives 2 Lino	0.000					
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WILD Selsty M. 295 Stoner Ave. #303. Westminster MD 31157	0	endin eath. or: A the fu	Satio	2 Accident investigation			es 2 □No			
WILD Selsty M. 295 Stoner Ave. #303. Westminster MD 31157	Ĕ	r Att ter d irect n by 1	ŧ	determined 286, Place of Injury - A	t home, farm, str ecify)	reet, factory, office		28f. Location (S City or Tox	Street and Number or F vn, State)	łural Route Number,
WILD Selsty M. 295 Stoner Ave. #303. Westminster MD 31157		urs al		On the last of the	learning dead	the annual at the time	a data and shape	and due to the	acusa(a) and manner	as stated
WILD Selsty M. 295 Stoner Ave. #303. Westminster MD 31157		Hosp 24 ho Fune stely f	lica	(Check only 2 Medical Examiner: On the basis of exam	knowledge, deal nination and/or ir	n occurred at the tim nvestigation, in my op	pinion, death occur	red at the time,	date and place, and di	ue to the cause(s)
WILD Selsty M. 295 Stoner Ave. #303. Westminster MD 31157		ithin a	Mec			29c. License	number		29d. Date signed (Mor	nth, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Evan Selsty M. 295 Stoner Ave. #303, Westminster M 31157			0.0		logist	D 00	3338	8	5/18/09	
Evan Selsty MD. 295 Stoner Ave. #203, Westminster MD 21157	•	MJ		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)				
		10		Evan Selsty MD. 295 Stone	er Ave.	#303.1	wesim in	sper m	A 21157	
Registrar MAY 19 2009 Jeneur B. Jacks		Sta	te							
		Registr	ar	MAY 19 2009 Jeneura	B. A	parke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 3. Time of Death Day Month Year 12:00 09 2009 May Harry E. Korab 4c. County of Death 4b. City, Town, or Location of Death Silver Spring Prince George's Birthplace (State or Foreign Country)

1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4a. Facility Name (If not institution, give street and number) Examiner Renaissance Gardens - Riderwood Village If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 **3** M 2 □ F Yrs Director 216-18-0616 February 17, 1921 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show ral", or items 23a or 28a-f shov Examiner must be retiffed at Director Maryland | Silver Spring Montgomery 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 20901 11109 Oakwood Street Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? within 72 hours after 1 Never Married 2 Married XYes 2 □ No Baltimore, Maryland 21215-0036 1 □Yes 2 🗷 No If Yes, Give Specify þ 3 ☐ Widowed 4 ☐ Divorced Ye ar or Dates: WWII "natural" Completed of Health and Mental Hygiene.
Item 27 is marked other than "natur other traumatic event, h. M. die. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Soft Drinks Industry Technical Director 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lydia Marie Toykkula ၉ Harry Emil Korab 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11109 Oakwood Street, Silver Spring, Maryland 20901 Virginia Evelyn Korab - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of I-Important: If ite any injury or ot 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park 05/14/2009 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service I 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List one one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary Artery Disease /Medical Due to (or as a consequence of) Examiner Diabetes Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed and burial-trar Due to (or as a consequence of) Box 68760. Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) the o 9 D Unknown 9 Unknown signed by I I be detach σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Congestive Heart Failure 1 ☐ Yes 2 x No 3 ☐ Probably 4 ☐ Unknown Completed page 25. Was case referred to medic Be 1 Tes 2 X No

Division of Vital Records, certificate has Hospital or Attending Physiclan: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director, I

Certification: To

27 Manner of Death

1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide

29a. Certifier

(Check only one)

31. Date filed (Month)

within 24 hours a

8+1

LVC MCGILC I	ULLULU						
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No		
red to medical	26. Place of Death (Check only one)						
No	Hospital: 1 Inpatient 2 I	ER/Outpatient 3 🗆 🛭	Home 5 ☐ Residence 6 ☐ Other (Specify)				
n 5 ☐ Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injur	y occurred		
6 Could not b determined	286. Place of Injury - At n	28e. Place of Injury - At home, farm, street, factory, office 28f. Location		28f. Location (Street ar City or Town, State	reet and Number or Rural Route Number, n, State)		
	nysician: To the best of my kniner: On the basis of examin and manner stated.				and manner as stated. It place, and due to the cause(s)		

. Signati	and title of certifier		
	Darlella	/10	

29c. License number D44156

29d. Date signed (Month, Day, Year) May 11, 2009

Maryland

White

Onset and Death

Year

Day

U.S.A.

10d. Inside City Limits

1 ☐ Yes 2 X No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rachelle Marie Alexion, M.D., 3160 Gracefield Road, Silver Spring, Maryland 20904

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-04146 2009 17673 State of Maryland / Department of Health and Mental Hygiene Simon Theodore King, Sr. Certificate of Death 1- For State Reg. No. Registrar

1. Decedent's Name (First, Middle,Last) 3. Time of Death 2. Date of Death Physician/ May 24, 2009 2105 hrs Simon Theodor King Medical Examiner c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Silver Spring 10843 Bucknell Drive 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 7. Age (In yrs, last birthday) 5. Social Security Number 6. Sex **Funeral** Country) China Days Hours 1942 577-62-6463 Months August 4, Director 66 1X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Yes 2 XNo s 23a or 28a-f show notified at once Wheaton Maryland Montgomery death with the Maryland Director 10g. Citizen of What Country? 10f Zin Code 10e Street and Number USA 20902 10843 Bucknell Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11 Marital Status or items 2 must be r If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc Armed Forces' 2 Married Never Married 2 X No Yes Asian 4 X Divorced 1 Yes 2 No specify: Specify: If Yes, Give Yaar þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Mental Health Pages 1 and 2 should be filed within 72 nt of Health and Mental Hygiene.

t: If iten 27 is marked other than other traumatic event, the Medical Psychologist 5+ Baltimore, MD 21215-0036 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Emmy Unknown Theodor King Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 103 Watkins Overlook, Rockville, MD 20850 19a. Informant's Name/Relationship (Type, Print) Simon Theodor King, Jr./Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition 29 May crematory or other place) Cremation 3 Removal from State 1 X Burial 2 Gate of Heaven Cemetery Silver Spring, Maryland 2009 Donation 5 Other Specify: 22 Name and Address of Collins Funeral Home Inc. Francis of Collins Funeral Home Inc. 500 University Blvd., W, Silver Spring, MD 20901 21. Signature of Funeral Service Licensee M 0085 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line Death Medical Hypertensive cardiovascular disease and cirrhosis Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): of liver Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit #I as noted, 23a,27,perME, g893 7/16/09 TT cal X AMENDED tending physician a use as the burial -X UNPENDED Physician/Medi certificate be 23d. Date of delivery Box 68760, 23c. If ves, outcome of pregnancy IF FEMALE: Day Vear 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown has been signed by the att Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I 0 Part II. Other significant conditions Yes 2 ✔ No 3 Probably 4 Unknown ģ Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? certificate has No No ✓ Yes 2 ✓ Yes 2 page 26.Place of Death (Check only one) the Hospital or Attending Physician: iin 24 hours after death. the Funeral Director: After this certifi pietely filled in by the funeral director, 25. Was case referred to medical Division of Vital Be Other₄ Residence 6 🗸 Other: Scene examiner? Hospital: 1 Nursing Home 5 DOA Inpatient 2 ER/Outpatient 3 2 1 V Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification Yes 2 1 X Natural Pending 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be or Town, State) Suicide determined (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical Tro the I within 2 and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b Signature and title of certifie May 25, 2009 O.C.M.E gree 30. Name and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001 OCME 2006

State

Registra

Margarita Korell MD

31. Date filed (Mon

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

2009

. Registrar's Signature

		Ctete of Manuford / Day			
		_ FOF	partment of Health and Ment	2000 176	7 .
_		negistal	ertificate of Death	Reg. No. 2009 15	14
Physic /Med		1. Decedent's Name (First, Middle, Last) Harriet Lee	M	105 09 2009 1141 A	
Exam	iner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death Anne Arundel	
and the same of th		Anne Arundel Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Annapolis // If Under 1 Year If Under 24 Hrs. 8, Da		ian
Funera Directo		218-30-2738 1 M 2 F 79 Yrs.	Months Dave Hours Min //	v 29 1929 Virginia 9. Birthplace (State or Fore Country) Virginia	
and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	Location	10d. Inside City Limi	its
Maryla f sho	P	Maryland Anne Arundel Annap	olis	1√2 Yes 2□1	NO
the 1	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?	
h with		701 Glenwood St. Apt 805	21401	USA	
deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	B. Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican	Yes or No- 14. Race - American Indian, n, etc.) Black, White, etc.	
after or it	by Fu	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 ☑ No Specify:	Specify: Black	
hours Engl		3 Widowed 4 Divorced Year or Dates:	redent's Usual Occupation	16b. Kind of Business/Industry	
in 72	plet	15. Decedent's Education (Specify only highest grade completed) (Girling Completed)	cedent's Usual Occupation ve kind of work done during most of working . DO NOT use retired)	Howard County	
iffed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Exaction of the state	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 9th 0	Custodian	Board of Education	on
al Hyl	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (Firs	st, Middle, Maiden Surname)	
at yially should be t and Mental s marked o	2	Willie Eldridge	Emma Hog		
				ute Number, City or Town, State, Zip Code) 2106) .L
t and the Health em 27 ther tr				101 Glen Burnie, Md.	
Pages nent of int: If it		TABURAL 2 Cremation 3 C Removal from State	position (Name of ematory or other place) nd Veteran 5-18-0		
permit. Pag Department Important: I any injury o	i	4 Estimates Section (Specify)	Winhame Recodes of BelliSons M		
permit. Departr Importa			821 West St. Annar		
		23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac of resp	Interval Between	
Physician		Immediate Cause (Final disease or condition	y artery Du	See Se Onset and Death	5
/Medica		resulting in death) Due to (or as a consequence of):	Maxdita		0
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ted	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Failuso	U' GUSCS)
be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):	, accorde	17	
te be	cal	d.		3	_
death certificate attending physi	ledi				
th cer tendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	3 ☐ Ectopic pregnancy	23d. Date of delivery Month Day Year	
he dearthe at the dearthed for	Physician/Medi	in the past 12 months? 1 Yes 2 No 4	5 Other (specify)	MOTAL Day Total	
w requires that the dispense signed by the should be detached	1	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?	,
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aw re	Completed	Solbetic neuropal	hes	24a. Was an autopsy 24b. Were autopsy findings availa prior to completion of cause	ıble
The lav	mo;			autopsy performed? death? 1 Yes 2 No 1 Yes 2 No	51
cian: ertific	Be	25. Was case referred to medical examiner?	26. Place of Death (Che	eck only one)	
Physi this o	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat		5 Residence 6 Other (Specify)	
ding Physician: The In. After this certificate har funeral director, page	ion	27. Menner of Death 1 Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation		Describe how injury occurred	
Atten death death cctor:	fical	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm,	ocation (Street and Number or Rural Route Number,		
alor /	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, State)	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.			
To the within To the Compl	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)	
22	Y	I Tak Lett MD	D0050756	5-12-2009	
300		30. Name and address of person who completed cause of death (Item, 23a) (Typ	Hally Aue 1	Annadolis MI) 214	51
	tate	31. Date filed (Month, Day, Year) NAY 15 2009 32. Fegistrar's Signature	house		-
Regis	trar	MATIB EUUS CENER D. Y			

09-04150 Kenneth Laird

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 17675 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day May 25, 2009 0257 hrs **Medical Examiner** Kenneth Wade Laird 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Cecil Union Hospital If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year **Funeral** Hours Min Months Davs Country Mary land Director 01/25/1963 214-88-8319 1 XM 2 46 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 XXes 2 No s 23a or 28a-f show e notified at once. 28a-f show Maryland Cecil North East Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code United States 109 Harvey Street 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12 Was Decedent Ever in U.S. 11. Marital Status Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.
Important: I (tiem 27 is marked other than "natural", or items 3 nigury or other traumatic event, the Medical Examiner must be 1 nigury or other traumatic event, the Medical Examiner must be 1 White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' 1 Never Married 2 X Married 2 X No Yes Specify: White Divorced f Yes, Give Year Yes 2XX No specify: þ 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Railroad Trackman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Shirley Bryan George H. Laird 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Maryland 21901 George & Shirley Laird 109 Harvey Street. North East. Parents 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Important: If ito injury or other t North Easter Wethodist Cemetery May 28, Cremation 3 Removal from State 2009 North East, Maryland Donation 5 Other Specify. 22. Name and Address of Facility Fineral Service Licensee Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and Combined Drug Intoxication (Alprazolam And Hydromorphone) failure. List only one cause on each line. /Medical Death Immediate Cause (Final disease xaminer or condition resulting in deat1) Due to (or as a consequence of): Sequentially list conditions, Dise to for as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical tending physician a use as the burial x UNPENDED 23a,27,28a-f per me g893 7-28-09 vt Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? Year 3 Ectopic pregnancy Month Day Live birth Fetal death Pregnant at time of death 5 Other (Specify) signed by the att be detached for 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions ģ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a. Was an certificate has been prior to completion of cause of autopsy performed? death? Yes 2 ✔ No No page 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Hospital: 1 ✔ Inpatient 2 Nursing Home 5 Residence 6 ER/Outpatient 3 DOA this 1 V Yes No 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death Certification: Natural 1 Yes 2 X No neral Director: , Pending subject ingested drugs 24 hours after death. 5-24-09 6:44 pm 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 X Suicide or Town, State) 100 East Harvey St. Could not be determined (Specify) residence To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated **Medical** 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME May 25, 2009 O.C.M.E. 30. Name and address of person who completed (ause of death (Item 23a)

Registra

Theodore M. King, Jr., MD.

31. Date filed (Month, Day, Year)

ÖRIGINAL

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Mayonth 27, 2009 10:20 AMM **Physician** James Edward Marceron /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Homewood at Crumland Farms Frederick 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Jan. 18 5. Social Security Number 7. Age (In yrs. last birthday) Year) 1917 Washington, DC **Funeral** Days **X**XM 2□ F 92 577-07-9448 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantural must be notified at once. 1 □Yes Z□No Frederick Maryland Director Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21702 7401 Willow Road, Apt. 251 AL Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∑Yes 2 □ No If Yes, Give 1941-1945 Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: White Specify: à 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Power Company Senior Foreman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Smith William James Marceron ೨ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5107 C Old National Pike, Frederick, MD 21702 19a. Informant's Name/Relationship (Type. Print) Mrs. Simone Phebus, Friend Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1XXBurial 2 Cremation 3 Removal from State Mt. Olivet Cemetery May 30, 2009 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify), 21. Signature of Funeral Bervice Lice ²²Keeney and degrees of Easility ford PA Funeral Home M00255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) signed by the a P.O. 9 Hlnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2 **N**O 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number May 27, 2009 30. Name and address of pers who completed cause of death (Item 23a) (Type, Print) 0 MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

		1 - State of Ma	•	artment of Hea rtificate of De		ental Hygie Reg.		17677
		Decedent's Name (First, Middle, Last)				2. Date of Death	2003	3. Time of Death
Physi /Med		Jacklyn Bernice Mon	rgan			May 2	Day Year 23 2009	6:09 P M
Exam	iner	4a. Facility Name (If not institution, give street and number) Frederick Memorial Ho	spital	4b. City, Town, or Loc Frede			4c. County of Death Frederic	
Funera Directo		219-36-4834 1□ M 2☑ F	(In yrs. last birthday) 69 Yrs.		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye April 17,	ear) Cou	place (State or Foreign intry) land
and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits
Mary Ff sho	ţ	Maryland Frederick	T.	Woodsboro				1 ☐ Yes 2 🔀 No
h with the 23a or 28a st be noti	al Director	10e. Street and Number 679 West Adams Circle		10f. Zip Code 21798	8	10g.	Citizen of What Cou United S	
Nore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced 12. Was Decedent E Armed Forces? 1 □ Yes 2 ☑ N If Yes, Give Year or Dates:	lo l	Mas Decedent of Hispa If Yes, specify Cuban, N 1 □Yes 2√ No S	anic Origin? (Spe Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White, Specify: Wh	
21215-0036 ad within 72 hours aft glene. er than "natural", or in the Wedical Expans	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5-	(Give	dent's Usual Occupation kind of work done durin DO NOT use retired)	n ng most of workin		D. Kind of Business/II	,
nd 2121 e filed within al Hygiene. I other than '	S	17. Father's Name (First, Middle, Last)		Cook	Mothor's Name	(First, Middle, Mai	Restaurant	-
Maryland of 2 should be file th and Mental Hy 27 is marked oth	To Be	Clyde Woodrow Lenhart			Pauline 1	sabelle Ma	ckley	
'e, Mar 1 and 2 sho Health and em 27 is m	1	19a. Informant's Name/Relationship (Type. Print) Barbara Tomko / Daughter	i i	ng Address <i>(Street and</i> etter Trail, I			•	ip Code)
Baltimore, permit. Pages 1 ar Department of Hea Important: If item:		20a. Method of Disposition 1⊠ Burial 2 □ Cremation 3 □ Removal from State 4□ Donation 5 □ Other (Specify)		sition (Name of matory or other place) ret Cemetery	May 28		. Location - City or T	
Baltimore, permit. Pages 1 an Department of Heal Important: If item 2 any injury or other	- AULKE	21. Signature of Funeral Service Liverises	M01433	2. Name and Address o eeney & Basfo 06 East Churc	rd P.A. Fu	meral Home	Marvland 21	701
		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do not enter					Approximate Interval Between Onset and Death
Physiciai /Medica Examine		disease or condition resulting in death) a. Due to (or as a conseque ce of):						seconds
	Examiner	Sequentially list conditions, if any, leading to himochate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Due to (or as a consequence of):						minutes
58760, Efficate be executed physician and sthe burial-transit	edical Exa	resulting in death) Last Due to (or as a	a consequence of):	Anemia	7 70000			hours
Box 6 sath certif	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
ecords, P.O. law requires that the das been signed by the 2 should be detached	₽ S	Part II. Other significant conditions contributing to death bu	n Part I.		23e. Did tobacco use contribute to the cause of death? 1			
DIVISION OF VITAI RECORDS, I or Attending Physician: The law requires thater death. Director: After this certificate has been signed in by the funeral director, page 2 should be each of the funeral director, page 2 should be a consideration.	Completed			•		24a. Was an autopsy performed	prior to c death?	topsy findings available ompletion of cause of
tal an: T tificat tor, pa		25. Was case referred to medical		26	S Place of Death	(Check only one)	Mo 1∐Yes	2 □No
† VI	o Be	examiner? 1 Yes 2 No Hospital: 1 Impatie	nt 2 🗌 ER/Outpatier	Other:			e 6 Other (Spec	cify)
On of Vital Reding Physician: The Ith. After this certificate has funeral director, page	rtion: 1	27. Manner of Death 1 Natural 5 Pending (Month, Day 2 Accident investigation	ry 28b. Time of Injury	Work?	2	28d. Describe how	injury occurred	
DIVISION To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Certification: To	a □ Cuisida 6 □ Could not be	iry - At home, farm, stre c. (Specify)	eet, factory, office	2	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
To the Hospital within 24 hours a To the Funeral I completely filled	edical (29a. Certifier (Check only one) 112 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner sta	fexamination and/or in	h occurred at the time, vestigation, in my opini	date and place, a ion, death occurr	and due to the caused at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
To the To the comp	Me	29b. Signature and title of certifier	MD	29c. License nu			Date signed (Month	
3		30. Name and address of person who completed cause of de	eath (Item 23a) (Type,	MDD674 Print) as Johnson			2/27/	2009
V		Yun Oh 4	GB Thomas	as Johnson	Drive;	Frede	rick, MD	21702
S Regis	tate	31. Date filed (Month, Pay, Year) 32. Registra	10 Similatrite	e12				

State Registrar 30. Name and address

Thomas

<u>31 E. Antietam St. Hagerstown, MD 21740</u> pistrar's Signature

of person who completed cause of death (Item 23a) (Type, Print)

J.Gilbert

21

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 200^{Ye ar} Month 5 Day **Physician** 13 12:06 AM Francis Peter Malitz /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Peninsula Regional Medical Center Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 12/5/1948 Birthplace (State or Foreign Country)
 _ _ _ 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 X M 2 □ F 170-38-9259 60 PΑ **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the World's Even. Inc. out the relified at 10a State 1 ☐ Yes 2(X)No Director MD Wicomico Willards 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 36250 Pine St. 21874 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 X No Specify Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Trucking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Malitz Veronica Mehalik 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health at
Important: If item 27 is
any Injury or other trau Donna Malitz / wife 36250 Pine St., Willards, MD 21874 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 5/15/2009 4 □ Donation 5 □ Other (Specify) Cape Henlopen Crem. Frankford, DE 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part Finer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ursease of injury that initiated events resulting in death) Last Due to (or as a consequence of) sician and burial-trans Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 🕅 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 X No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

Division of Vital Records, P.O. Box 68760,

Maryland 21215-0036

altimore,

The law requires that the death certificate be executed To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

BA5

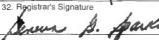
DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year) 18

29b. Signature and title of

30. Name and a



ho completed cause of death (Item 23a) (Type, Print)

NWE

Vo

29d. Date signed (Month, Day, Year)

109

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month May 2009 **Physician** 0659 Michael Patrick Moore /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Westminster Carroll Hospital Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 6. Sex 5. Social Security Number **Funeral** Days Months M 2□ F 50 12 1958 Dec 212-72-5429 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State 10b County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examination and process. 1 □Yes 2 □No Director Westminster Carroll MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21158 1038 Cherrytown Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) N/A Disabled 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nancy Smith James Ralph Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 330 Lovely Lane Ct., New Oxford, PA Nancy Basler/mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Carroll Cremation, Inc 5/19/2009 Hampstead, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Şervice Licensee Prints Funeral Home and Chapel, P.A. 21157 412 Washington Road Westminster, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Anewhom dissection AORAIC Immediate Cause (Final disease or condition resulting in death) Thoracic **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical attending pl 23d. Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 2 □ No signed by the a P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown icate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2. R No 1 □Yes 2 No certificate 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient this To the Hospital or Attending Ph. within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral to 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 151705 2009 NJL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), Westminster, MD 211
MPANSURIYA 349 Malwim DR, Westminster, MD 211 0 'AMSURI 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Amended Item 15 per F.D. 05/19/2009 Carroll County, wj1
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician Bonnie Lou Mehaffie <u>8:</u>15p [™] 15, 2009 May /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Hampstead 2439 Fairmount Rd., #35 If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 KF 212-50-2846 11/30/1946 62 MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County items 23a or 28a-f show ner must be notified at 1 □Yes 2 No Carroll Hampstead MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21074 2439 Fairmount Rd., #35 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status "natural", or item Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2√2 No Specify: Specify: white þ 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) hair salon shampoo technician 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Genevive Utz Woodrow Weller ပ 19a. Informant's Name/Relationship (Type. Print) husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once. 2439 Fairmount Rd., #35, Hampstead, MD 21074 Anthony P. Mehaffie, Sr. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Memorial 5/20/2009 Finksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licensee M00741 21074 934 S. Main St., Hampstead, Md. demmen Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cancor **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and Due to (or as a consequence of): attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Whiknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ ▶ € 24a. Was an After this certificate has autopsy performed? Yes 2 ☑ No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 40 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To filled in by the funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year) 5 ☐ Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

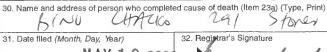
Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Hospital or Attenc within 24 hours after death To the Funeral Director;

Baltimore, Maryland 21215-0036

State

Registrar

B(NU 31. Date filed (Month, Day, Year)



2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** DORIS JEAN MESSER 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Memorial 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 7. Age (In yrs. last birthday) **Funeral** Days Min. 1 □ M 2 🔽 F Hours 220-28-074 MARYLAND Director March Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modical Eventines must be notified at 1X Yes 2 □ No Director QUEEN ANNE'S QUEENSTOWN MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21658 USA 320 DEL RHODES AVENUE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No WHITE Specify: ₹ DORY 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 RECEPTIONIST CHESAPEAKE COLLEGE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FRANCES WOOLFORD VIRBROOK N. BEECHER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 320 DEL RHODES AVENUE, QUEENSTOWN, MD 21658 DENNIS MESSER/ HUSBAND permit. Pages 1 and Department of Healt Important: If item 2: any Injury or other: once. 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION MAY 15,2009 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Lices FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final years **Physician** disease or condition resulting in death) me care /Medical Due to ()r s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed Exami attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 □Yes 2 No

Division of Vital Records, l or Attending F efter death.

Be

Certification: To

Medical

State Registrar

To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A

After this

filled in by the

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

5 Pending

investigation

determined

6 ☐ Could not be

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Injury at Work?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

28a. Date of Injury (Month, Day, Year)

NS 2195. Washreton St. Registrar's Signature

31. Date filed (Month, Day, Year)

25. Was case referred to medical

1 Yes 2 No

27. Manner of Death

2 Accident

3 Suicide

29a. Certifier

4 Homicide

1. □ Naturai

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 5 7 7 3 / 2009 1125a Montgomery ,Jr. Lional /Medical 4c. County of Death $P \cdot G$. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Cheverly Prince Georges Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 11 M 2□ F 19 Wash.DC Director 578-17-4843 6/07/1989 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f shor 1 XYes 2 No Bladensburg Funeral Director P.G. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ò item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examinal nates be USA 20710 4407 56th Avenue Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify.Black 1 ☐ Yes 2 XNo Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Education student 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked ot Wanda Morse Lional Montgomery, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4407 56th Avenue, Bladensburg, MD, 20710 of Health item 27 i Wanda Morse/mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State jo := 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or once. 5/16/09 Landover, MD Harmony Memorial 420 H Street NE. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility B.K. Henry Funeral Home Wash, DC, 20002 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Fatal Cardiac Arrythmia /Medical Due to (or as a consequence of): Examiner Wolfe Parkinson White Syndrome 2mnths Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached for Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been s funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□Yes 2□No 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ R R/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Anatural 5 Pending investigation 1 ☐ Yes 2 ☐ No the 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

UL 5

State Registrar 31. Date filed (Month, Day, Year)

MAY 1 8 2009

Name and address of pe

HEELER 1221 Mer cantile LN, Largo, MD. 20774

ar) 32. Registrar's Signature

on who completed cause of death (Item 23a) (Type, Print)

D0037529

5/5/09

09-04129 Ke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2009 17684

vin Meyers			artment of Health and Mer <i>rtificate of Death</i>		. No.	
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death
edical Exami		Kevin Francis Meyers		May 24, 20	09	0904 hrs
		4a. Facility Name (if not institution, give street and number) 1859 E. Old Phil Road	4b. City, Town, or Location Elkton	of Death	4c. County of Death Cecil	
	4	5. Social Security Number 6. Sex 7. Age (In yrs. I		ler 24Hrs. 8. Date of Birth	(MM/DD/YYYY) 9. Birth	hplace (State or
Funeral Director		219-76-0971 1XM 2F 41	Yrs. Months Days Hour		1968 Foreign	n ^{untry} Maryland
ŕ	H	Usual Residence of Decedent 10a. State 10b. County 10c. City	, Town or Location			10d. Inside City Limits
d how a		Maryland Cecil	Rising Sun			1 Yes 2 X No
ne Maryland or 28a-f show any fied at once.	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Coun	ntry?
the M	ä	167 Slicers Mill Road	21911		Inited Stat	es
h with	Funeral	11. Marital Status 12. Was Decedent Ever in U	J.S. 13. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica	rigin? (Specify Yes or No- n, Puerto Rican, etc.)	14. Race - Americ White, etc.	can Indian, Black,
er deat or ite	Fu	1 Never Married 2 Married 1 Yes 2 No 3 Widowed 4 XXDivorced If Yes, Give Year	1 Yes 2 X No specifi	v:	Specify: Whi	te
irs afte iural", imine	ğ	15. Decedent's Education (Specify only highest grade completed)	16a, Decedent's Usual Occupation (Give	e kind of work done	16b. Kind of Business/I	
72 hou	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NO	T use retired)	m 1. f	
036 vithin ene. rr tha	du	12	Diesel Mechanic	er's Name (First, Middle, M	Trucki	ng
15-C filed v I Hygi ed oth	e Co	17. Father's Name (First, Middle, Last) William Meyers		Carole Stite:		
, MD 21215-0036 and 2 should be flied within 72 hours after death with the Maryland eath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho- traumatic event, the Medical Examiner must be notified at once.	o B	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and No	umber or Rural Route Num	ber, City or Town, State	e, Zip Code)
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and N Important: If item 27 is r injury or other traumatic		Garole Housel / Mother George Housel / Stepfather	167 Slicers Mill		ng Sun, Mar	yland 21911
re, land f Heat If item		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State	. Place of Disposition (Name of cemetery, crematory or other place)	May 28,	20c. Location - City or	Town, State
Pages Pages nent o ant: I		4 Donation 5 Other Specify: Ma	verdale Crematory	2009	Newark, De	laware
Salti ermit. epartr mport njury		21. Signature of Funeral Service Licensee	22. Name and Address of Faci	lity Crouch Fund	eral Home	1 10100
		23a. Part. Enter the disease, or complications that caused the deat	th. Do not enter the mode of dying, such as	Street No. scardiac or respiratory arre	rth East, M est, shock, or heart	Approximate interval
Physician /Medical		failure. List only one cause on each line. Hyperten	sive cardiovascula:	disease as	sociated	Between Onset and Death
caminer		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence)	of):			
	Ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence	of):			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	of):			
mo cuted transit	Exa	events resulting in death) Last Due to (or as a consequence d.				
Records, P.O. Box 68760, The law requires that the death certificate be execute icate has been signed by the attending physician and page 2 should be detached for use as the burial - tran	Medical	■ MENDED 23a,27	per me g893 7-28-0)9 vt		
760 ficate l g phys	//Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pre		opic pregnancy	23d. Date of deliver Month	ry Day Year
Sox 6876 leath certificate e attending phy for use as the	sician/	past 12 months?	_			
. Bo he dea y the a	Phys	Part II. Other significant conditions contributing to death but not	t resulting in the underlying cause given in	Part I. 23e. Did to	obacco use contribute to	the cause of death?
P.O. s that th gned by e detach	₽	Part II. Other significant conditions	researing in the energy ing	1 Ye	s 2 No 3 Pro	obably 4 🗸 Unknown
ords, P.C w requires that is been signed I should be deta	eted			24a. Was auto		utopsy findings available completion of cause of
e law e has l ge 2 st	Completed			perfo	rmed? death?	
of Vital Records, ng Physician: The law require ther this certificate has been is meral director, page 2 should I	ပိ	25. Was case referred to medical		ath (Check only one)		
Vita hysicia this ce	To B	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA Other		Residence 6 • Oth	er: Scene
_ = _ ~ =		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury at W		how injury occurred	
ivisior or Attend after death Director:	catio	2 Accident Investigation 28e Place of Injury - At	t home, farm, street, factory, office building		Street and Number or F	Rural Route Number, City
Division pital or Attendiours after death. reral Director: /	Certification:	3 Suicide 6 Could not be determined (Specify)		or Town,		
Division of Vital I To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Divector: After this certifi completely filled in by the funeral director,	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowled one) Medical Examiner: On the basis of examination	edge, death occurred at the time, date and n and/or investigation, in my opinion, death	place, and due to the cau occurred at the time, date	se(s) and manner as sta and place, and due to	ated. the cause(s)
To with	Mec	and manner stated. 29b. Signature and title of certifier	29c. License numi		29d. Date signed (M	fonth, Day, Year)
		Theodon U Kind or	O.C.M.E.	OCME	May 25, 2009	
\		30. Name and address of person who completed cause of leath (It		Baltimore, MD 2120	1	
	tate	Theodore M. King, Jr., MD. Assistant Medica 31, Date filed (Month, Day, Year) 32, Registrar's Sign		Datamore, IVID 2120		
Regis		111N 0 0 0000 A	parled			
DHMH 17 Rev 1/	2001		ORIGINAL			

Amended # 19a, MLU Per: FD Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05/22/09, Allegany Co. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** May 04, 2009 5:05 A Donnie G. Nightingale /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany Frostburg 187 McCulloh Street If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, 6. Sex **Funeral** Hours Months Days 1 M 2 F North Carolina June 02, 1934 74 Director 578-44-6408 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a State 10b. County 28a-f show or items 23a or 28a-f shoveniner must be notified at 1 Yes 2 No Director Frostburg Allegany Maryland 10e. Street and Number 187 McCulloh Street 10g. Citizen of What Country? 10f. Zip Code U.S.A. 21532-Examiner must by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status ould be filed within 72 hours after Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) board of elections Chief Judge 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vonnie Johnson John Edward Lewis Pages 1 and 2 should 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21532-Maryland William W. Nightingale 187 McCulloh Street Frostburg of Health a husband other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Department of Important: If its any injury or o Burial 2 □ Cremation 3 □ Removal from State May 06, 2009 Frostburg Maryland Frostburg Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 4RS **Physician** nd57460 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The lay requires that the death certificate be executed burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the SS IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregna 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death ed by the a 9 Unknown 9 Unknown signed by the sign of the sign 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 ☐ Yes . Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an funeral director, page 2 s autopsy perform certificate l 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗀 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Medical Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of P `> ause of death (Item 23a) (Type, Print) Bishop Walsh Rd. Chimberland, 30. Name and address of person who co-31. Date filed (Month, Day, State 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3-27PM **Physician** 2009 Druce. 05 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Berlin Worsester General Hospital Atlantic Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/23/1927 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex Funeral Days 1 X M 2 □ F 204-22-1615 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examires must be rectified at 1 ☐ Yes 2 👿 No Director Worcester Berlin 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21811 11655 Rotherwood Lane Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc DOB $10l \Rightarrow l \cdot q$ 1937DOD $5/l \cdot l \cdot 2009$ Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify white 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Owner/ Operator Flag Shop 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dr. Tom Holland Nelson Edith Emma Ford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David B. Nelson / son 5848 Raleigh Circle, Castle Rock, CO 80104 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Paul's Churchyard 5/20/2009 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 Approximate Interval Between Onset and Death caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Previndinia Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of) 1 5 Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Likely 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown To the Funeral Director; After this certificate has been sompletely filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? CAD autopsy performed? 1 ☐ Yes 2 No Subcarinal Mass 1 ☐ Yes 2 ☐ No ر ا ا ا 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division To the Hospital or Attending within 24 hours after death.
To the Funeral Director; After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2009 00062130 05

Registrar

State

BA 5+1

DHMH 17 Rev 1/2001

21811

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9733

Anola

31. Date filed (Month, Day, Year) MAY 18 2009

Healthway

32. Régistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of	Marylan		rtment of H		Mental Hyg	giene	
			Registrar			Cei	tificate of l	Death		Reg. No.	9 1/68/
	Physici		1. Decedent's Name (First, Middle, Laurann	Last)	P	eterso	n		2. Date of Dea Month May 16	Day Ye	ar 3. Time of Death 11:10 A M
1	/Medio Examir		4a. Facility Name (If not institution,	give street and numb	er)		4b. City, Town, or	Location of Deat		4c. County of D	
and the			WMHS-Braddoc	k Campus			Cumbe	rland		All	legany
	Funeral		5. Social Security Number 6			last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		h year) 9.	Birthplace (State or Foreign Country)
	Director		218-24-8109	1□M 2∏F	80	Yrs.	Days	Tiodio Iviini	03/18/1		Maryland
	pu ,		Usual Residence of Decedent 10a. State 10b. County		100 03	y, Town or Lo	netion				10d. Inside City Limits
	arylan show	7		0.001	100. 01		Vale				1 ☐ Yes 2 ☑ No
	he M. 28a-f otifie	ectc		any						10- 02: 110:	A
	be filed within 72 hours after death with the Maryland that Hygiene. dother than "natural", or items 23a or 28a-f show event, it where I have miner must be notified at	Funeral Director	10e. Street and Number 541 Maryland	Street			10f. Zip Code 215	502		10g. Citizen of What USA	Country?
	ms 2	ner	11. Marital Status	12. Was Decede		S. 13.\	Nas Decedent of H Yes, specify Cuba	ispanic Origin? (S	Specify Yes or No-	14. Race - A	American Indian,
9	or ite	Ē	1 ☐ Never Married 2 【 Marrie	d 1 ☐ Yes 2	™ No				to Rican, etc.)		/hite, etc.
03	ral", c	l by	3 Widowed 4 Divorced	If Yes, Give Year or Date	es:		I∐Yes 2M∏No	Specify:		Specify:	White
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21	ithin ne.	ldu	Elementary/Secondary (0-12)	College (1-4	or 5+)	life. I	DO NOT use retired	1)	3		
2	ed wi	Co	12			Cle	rk			Retai	1
pu	tal H d oth	Be	17. Father's Name (First, Middle, La	0 .		Clos		18. Mother's Na Ruth	me <i>(Fir</i> st, <i>Middle,</i> E	Maiden Surname)	Robison
Уa	ould Men arke	ဥ	Byard			Glas					
Maryland	12 sh th and 7 is m traum		19a. Informant's Name/Relationshi Allard Guy Pete:		/ Hush					er, City or Town, Sta 1e. MD 2	te, Zip Code) ! 1 502
e,	1 and Healt em 2		20a. Method of Disposition	. 5011, 51					Date	20c. Location - City	
Baltimore,	nt of If its		1 🛣 Burial 2 ☐ Cremation 3		ne i		sition (Name of natory or other place			•	
Ħ	it. Perriment		4 □ Donation 5 □ Other (Spe		Sur		morial P			Cumberla	
Bal	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event, ITEM ODICE.		21. Signature of Funeral Service L	dan						rland, MD	21502 P.A.
Е			23a. Part 1. Enter the disease, or c shock, or heart failure. List o	omplications that cau	sed the deat	h. Do not ent	er the mode of dyir	ng, such as cardia	c or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			_ 06	stroky	109	dic	,	Onset and Death
	/Medical		resulting in death)		as a conseq				1		7
	Examiner	_	Sequentially list conditions	b							
	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseq	uence of):					
	execu and al-trar	xar	that initiated events resulting in death) Last	c Due to (or	as a conseq	uence of):					
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical E	,	d							
687	ificat g phy as the	edic		u							
Вох	eath certific attending p for use as	M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco						23d. Date o	f delivery
-	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregna	th 2□Feta nt at time of o		Ectopic pregnanc Other (specify)	у		Month	Day Year
P.0	at the de by the stached	Physician/Me	9 Unknown	9 ∐ Unknow	/n						
	res tha signed be det	by P	Part II. Other significant condition	s contributing to deat	h but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	obacco use contribu	te to the cause of death?
Records,	w require s been si should b								1 🗆 Y	′es 2∐No 3[Probably 4 Unknown
ည္ထ	aw re	Completed							24a. Was	an 24b. Wer	e autopsy findings available r to completion of cause of
Ä	: The law icate has l	E							autop perfor 1 □ Yes	rmed?/ deat	th? Yes 2 🗆 No
ital	slclan: The certificate } irector, page	ao I	25. Was case referred to medical					26. Place of De	ath (Check only o		100 2 1110
of Vital	Physician: r this certifica ral director, p	To B	examiner? 1 Yes 2 No	Hospital: 1 🔀 Inp	atient 2 🗆	ER/Outpatier	nt 3 DOA Oth	er: 4 🗆 Nursing I	Home 5 Resid	ience 6 ☐ Other (Specify)
	ding Ph h. After th funeral	L:	27. Manner of Death	28a. Date of	Injury Day, Year)	28b. Time of Injury	28c. Injur Worl	y at	28d. Describe h	now injury occurred	
Ö	Attending ir death. ector: After by the fune	atic	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investiga	tion	Day, roa.,	,,		Yes 2 □ No			
Division	r Att	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place of	Injury - At ho , etc. <i>(Speojt</i>	ome, farm, str	eet, factory, office		28f. Location (S City or Tox	Street and Number o	r Rural Route Number,
	ital or irs afte ral Dire	Cer				/					
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: / completely filled in by the fi	Medical		Physician: To the bas xaminer: On the bas and manne	is of examina						
	To the within 2 To the complex	Me	29b. Signature and title of certifier	1//			29c. Licens	e number		29d. Date signed (M	fonth, Day, Year)
	2		•	1/11			D36	766		May 17,	2009
			30. Name and address of person w	ho completed cause	of death (Iten	n 23a) (Type.	Print)			. ,	
	MLS		Vikramadi	tya Poonai			24 Seton	Drive, 0	Cumberlar	nd, MD 2	1502
	Sta	te	31. Date filed (Marth, Day Year)	32. Reg	istrar's Signa		1				

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma	arylan		artment of t rtificate of		ana Me		giene Reg. No.	200	9	1768	8
			Decedent's Name (First, Middle, I	.ast)						2. Date of Dea				3. Time of Death	_
	Physicia /Medic		Margaret	Ann	1		Parker			May 11		109	ar .	2122	/
	Examin		4a. Facility Name (If not institution, g				4b. City, Town, o					County of De			
A			WMHS-Memorial 5. Social Security Number 6.	•	a (In vre I	ast birthday)	Cumber If Under 1 Year		24 Hrs. T	8. Date of Birt	1	Alle			an an
	Funeral Director		215-16-4758		86	Yrs.	Months Days	Hours	Min.	(Month, Da)	, Year)			ce (State or Foreigy) Virginia	
	D		Usual Residence of Decedent												
	arylar show	'n	10a. State 10b. County MD Alle	egany		, Town or Lo Cumber:							100	I. Inside City Limit 1 ☑ Yes 2 ☐ N	
	the M 28a-f notifie	Director	10e. Street and Number	garry		Jumper.	10f. Zip Code				10a. Citi	zen of What	Countr		_
	3a or	al Di	618 Frederick	Street				21502				USA			
	ems 2	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S	S. 13. \	Was Decedent of his Yes, specify Cub		gin? (Spec	cify Yes or No-		14. Race - A			_
50	or It	by Fu	1 ☐ Never Married 2 ☑ Married	1 ☐ Yes 2 🕅 N if Yes, Give	10		1 □Yes 2√∑No	Specify:	,			Specify:			
215-0036	72 hours after death with the Maryland natural", or Items 23a or 28a-f show Jisal Examiner must be notified at		3 ☐ Widowed 4 ☐ Divorced 15. Decedent's	Year or Dates:		16a Dece	dent's Usual Occup	nation			16b. Kii	nd of Busine	Whi ss/Indu		
2	e. In "na	Completed	(Specify only highest of Elementary/Secondary (0-12)	grade completed) College (1-4or 5-		(Give	kind of work done DO NOT use retire	durina most	of working	g			00,11140	,	
7	ygiene rygiene er tha	Com	10		T)	Н	omemaker				Н	ome			
ana	be file	Be	17. Father's Name (First, Middle, La William	st)	Mon	rison		18. Mother Ava	r's Name	(First, Middle,	Maiden		oss		
Ĕ	hould d Mer marke matic	٦	19a. Informant's Name/Relationship	(Time Brint)	PIOT	1	ng Address (Street		a or Dumi	Doute Number	- City			No de l	_
2	od 2 s utth an 27 is r trau		Raymond Parker				Frederic						215		
ē,	is 1 ar		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of natory or other pla	ce)	Da	ite	20c. Lo	cation - City	or Tow	n, State	
Банитог	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Montail Hygiene. Department of Heath and Montail Hygiene. Important: If then Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modrial Examiner must be notified at once.		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			berlar	nd Cremat	ory 0				berla			
Za II	ermit. eparti nport ny inj nce.		21. Signature of Funeral Service Lic	ensee	/		2. Name and Addre				-			•	
	20 = % O		23a. Part 1. Enter the disease, or co	Comin	AllAl-		104 Decat					id, MD	_	1502 Approximate	_
	3hi.i		shock, or heart failure. List on Immediate Cause (Final	ly one cause on each lin	ne.			ng, such as	cardiac oi	respiratory at	1631,		1 1	nterval Between Onset and Death	
1	Physician /Medical		disease or condition resulting in death)	Pa. Intest Due to (or as a			uction						+		_
	Examiner		Coguentially list conditions	b		•									
7	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exerts.	Due to (or as a	a consequ	ence of):									
	execut and al-tran	xan	that initiated events resulting in death) Last	c Due to (or as a	a consequ	rence of):							+		_
00/00	te be e ysiciar e buria	edical E		d.											
8	ng phy as th		IF FEMALE:												_
Š	ath ce ittendi	Physician/M	23b. Was decedent pregnant In the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal	death 3	☐ Ectopic pregnan	су			1	23d. Date of Month	-	/ Pay Year	
5	he de the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	t time of d	eath 5	Other (specify) _							.,	
ν. Γ	that the ned by detail		Part II. Other significant conditions	contributing to death bu	ut not resu	ılting in the uı	nderlying cause giv	en in Part I.		23e. Did to	bacco u	se contribute	e to the	cause of death?	
vecords,	quires en sig uld be	ed by	Diabetes Mell	itus		-				1 D Y	es 2[□ No 3□	Probal	bly 4∭ Unknow	/n
ည် သ	law re as be 2 sho	Completed	Osteoporosis							24a. Was autop		24b. Were	autops	sy findings availab	le f
=	: The cate h	Com								perfo	med?	death	1? 'es 2		
V 110	ector,	Be	25. Was case referred to medical examiner?	Hospital:			Lott			(Check only o					_
5	Phys rrthis sral dii	. To	1 ☐ Yes 2 📉 No 27. Manner of Death	1X Inpatie		ER/Outpatier 28b. Time of	II 3 LI DOA			ne 5 🗌 Resid 8d. Describe h			Specify)		_
VISION	nding ath. r: Afte e fune	ertification:	1 X Natural 5 ☐ Pending 2 ☐ Accident investigat	(<i>Month, D</i> ay ion	y, Year)	Injury	f 28c. inju Wor M 1 [ńk?]Yes 2.∐n			1.	,			
2	r Atte er dez recto	tific	3 Suicide 6 Could not determine		ury - At ho	me, farm, str	eet, factory, office		21	8f. Location (S	Street an	d Number or	Rural	Route Number,	
2	oital o urs afi eral Di	O	On Carlifford ATT of the												_
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner sta	f examina	wiedge, deat tion and/or in	n occurred at the t vestigation, in my	ime, date an opinion, dea	d place, a th occurre	ed at the time,	cause(s) date and	and manne diplace, and o	r as sta due to t	he cause(s)	
	To the within To the comple	Me	29b. Signature and title of certifier			(29c. Licen	se number			29d. Dat	te signed (Mo	onth, D	ay, Year)	
	3/2		Benex	WOOB.	,	mi	/ 11	54411			Ма	ıy 12,	200	9	
		Ì		o completed cause of de	eath (item	23a) (Type,	Print)		C	h = - 7 =	a 1	(D 04)	E00		
	nds	10	Beverly C	alkins, M.I	ar's Simnai	ture factor	emorial A	venue	, cum	perian	u, M	טן צו:	502		_
	Sta	IC.	MAV 1 5 700) A	A	No R. N.									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 12514 Pamela Sue Polley 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Date of Birth Month, Pay, 19968 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 41 Yrs. Social Security Number 6. Sex Months 1 ☐ M 2 ☐XF 220-82-5723 P.A Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Funkstown Director Washington 1 Yes 2 □ No MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21 Wye Oak Drive U.S.A. 21734 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian. 11. Marital Status Black, White, etc 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married white 1 ☐ Yes 2√2 No Specify: ò 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) residence Elementary/Secondary (0-12) 9th grade College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dorothy Herall Paul Smith ပ 19a. Informant's Name/Relationship (Type. Prinaughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 Wye Oak Dr. Funkstown, MD 21734 Crystal Donivan 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) May 21, Clear Spring, MD 1 Surial 2 ☐ Cremation 3 ☐ Removal from State New Life Cemetery 2009 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc
P.O.BOX 310 Clear Spring, MD 21722 21. Signature of Funeral Service License Laute Long 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acquired Immune Deficiency Syndrome Immediate Cause (Final disease or condition resulting in death) Due to (or a a consequence of): Toxophymosis Sequentially list conditions. Examiner Due to (or as a consequence or) ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 1 □Yes 2 🖼 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 4No 1 Hipatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 28c. 5 Pending investigation

requires that the death certificate be executed Box 68760, P.0. of Vital Records, Division

attending physician and for use as the burial-trans Physician/Medical signed by the a d be detached for ð Completed peen cate has l page 2 s certificate funeral director, Be After this Certification:

Funeral

Director

28a-f show

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinst must be notified at

"natural", or it

72 }

filed within I Hygiene. other than "

12 should be filed w h and Mental Hygie 7 is marked other tl

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traun once.

Physician

/Medical

Examiner

Saltimore, Maryland 21215-0036

or Attending vithin 24 hours after death.

To the Funeral Director: After completely filled in by the fur

State

29b. Signature and title of certifier

6 ☐ Could not be

29c. License number

162588

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

2009

Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Haperstown, M 251 B. Antietam St. JUDITH MBAOUA, RD

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Mg

1 Natural

2 Accident

4 Homicide

(Check only

3 Suicide

29a. Certifier

Medical



and manner stated

Registrar

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Vipul Maheswari Kella, M.D., 9901 Medical Center Drive, Rockville, Maryland

32 Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 11394 M terson 05 2009 /Medical 4c. County of Death 4a. Fagility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** University of Mayland Mechal Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Days 1 ☐ M 2 🗷 F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location or other traumatic event, the Medical Examiner must be notified at 1 ☑Yes 2 ☐ No Be Completed by Funeral Director Riverdal 10g. Citizen of What Country? 10e. Street and Number 20737 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐Yes 2 🔼 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ONTRACH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau 9900 Bold Hill Bouche 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Landover 05-20-09 ARMONI 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The 14003 21. Signature of Funeral Service Licensee ST. N.W Wash, D.C Zooil Upshon 23a. Parm. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Endocard to **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? Year Month Day within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the sempletely filled in by the funeral director, page 2 should be detached it 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 No 3 Probably 4 Unknown 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 **N**0 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 27, Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 13/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) aure Punch 225. Green 21201 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 18 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) M May 11, 2009 630A David Page 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Suburban Hospital Montgomery Bethesda 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/24/1922 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours South Carolina 229-12-0420 87 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No Montgomery Montgomery Village 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 18714 Nathans Place 20886 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ሺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify. 3 X Widowed 4 □ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Dry Cleaning Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unobtainable Unobtainable 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) /Son Richard Christopher Page Deans 18714 Nathans Place, Montgomery Village, MD 20886 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Fort Lincoln Crematory 5/14/09 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simple Tribute 21. Sign ture of Juneral Ser, ce 1040 Rockville Pike, Rockville, MD 20852 Approximate Interval Between Onset and Death 23a. Part 1. Enjor the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of his rt failure. List only one cause on each line. 23d. Date of delivery Month Day Year use contribute to the cause of death?

29d. Date signed (Month, Day, Year)

May 6, 2009

20814

Physician /Medical **Examiner** 1-

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, It is in all as or instruction and injury or other traumatic event, It is in all as or instruction.

Baltimore, Maryland 21215-0036

5/6/09 0630 AM

/Medical

Funeral Director

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Completed

Be ပ MD

the attending physician and signed by t d be detach has completely filled in by the funeral director, within 24 hours after death To the Funeral Director:

Physician; The law requires that the death certificate be executed

Hospital or Attending

disease	ate Carre (Final or condition	Congestive	Heart Fai	lure		1	Onset and Death
	g in death)	Due to (or as a consect Progressive	uence of): re Renal Fa	ilure			
Cause (I	tially list conditions, ading to immediate Enter Underlying Disease or injury	Due to for as a sonsec	ushes of):				
resulting	ated events in death) Last	c	uence of):				
in th	ALE: s decedent pregnant he past 12 months?]Yes 2 □ No	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 🗆 Ectopic	pregnancy specify)		23d. Date of de Month	livery Day Year
Part II. O	ther significant conditions o	ontributing to death but not res	ulting in the underlying	cause given in Part I.		use contribute to	o the cause of death? robably 4X Unknown
					24a. Was an autopsy performed? 1 □ Yes 2 ♣ N	death?	utopsy findings available completion of cause of
	case referred to medical			26. Place of De	eath (Check only one)		
	Yes 21 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	OOA Other: 4 In Nursing	Home 5 ☐ Residence	6 ☐ Other (Spe	ecify)
1111	ner of Death Natural 5 Pending Accident investigation	28a. Date of Injury (Month, Day, Year)		28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	iry occurred	
	Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, facto	ry, office	28f. Location (Street a City or Town, State	nd Number or Ri e)	ural Route Number,
29a. Cer	rtifier 1X Certifying Ph	ysician: To the best of my kn	owledge, death occurre	ed at the time, date and pla	ce, and due to the cause(s) and manner a	s stated.

Sujoy Ghosh Tagore, M.D. 8600 Old Georgetown Road, Bethesda, MD

State

Medical

29b. Signature and title of certifier

31. Date filed (Month Registrar

30. Name aperaddress of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

066304

09-04197 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Da'Shaun L. Paul State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 3. Time of Death Physician/ 2 Date of Death 1. Decedent's Name (First, Middle,Last) Month Day May 26, 2009 0915 hrs Medical Examiner Da'Shaun Lamont Paul 4c. County of Death 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Talbot Faston Memorial Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 7 Hours Director 215-83-4199 10-19-2008 1 M 2 F Maryland Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 Yes 2 No 28a-f show or items 23a or 28a-f shomust be notified at once, Dorchester Hurlock Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country USA 21643 7038 Beulah Road Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes Specify: Black If Yes, Give Year Yes 2 No specify: Widowed 4 Divorced tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Pages 1 and 2 should be filed within tent of Health and Mental Hygiene. Never worked Never worked 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Vateasa Jefferson Sean 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print Preston, Maryland 21655 P.O.Box 31, Marilyn Neal 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition crematory or other place) Park 1 Burial 2 Cremation 3 Removal from State Easton, Maryland 06-06-09 Richards Mem. Important: Donation 5 Other Specify 22. Name and Address of Facility 21 Signature une Bennie Smith Funeral Home Transplications that cluster the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval and I. Enter the disease **Physician** Between Onset and failure. List only one cause on each line /Medical Death Sudden infant death syndrome (SIDS) Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical AMENDED 23a,27, perm, E g893 7/14/09 TT XUNPENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Dav Year Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 1 🗸 Yes ✓ Yes 2 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: Other₄ Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other 1 Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death 1 X Natural Yes 2 No Pending 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Certification: Investigation 3 Could not be Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

State Registrar May 27, 2009

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Warren Donovan Reed 16, 16:10pM 2009 May /Medical 4c. County of Death 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington 12652 Pecktonville Road Big Pool If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 11-2-1949 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 12 M 2□ F Months Days MD 59 Director 219-52-1732 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 ie marked other than "naturel", or Iteme 23e or 28e-f ehow ary or other traumetic event, the Marylan Examinar want be notified at 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 ☐ Yes 2 ▼No Washington Big Pool MD Be Completed by Funeral Director 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number U.S.A. 21711 12652 Pecktonville Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊡Yes 2 □ No If Yes, Give Year or Dates: 14 Race - American Indian. Black, White, etc. Never Married 2☐ Married _{Specify}white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) n/a disabled 12th grade O 18. Mother's Name (First, Middle, Maiden Sumame) Freida Lois Shives 17. Father's Name (First, Middle, Last)
Warren Edison Reed 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9545 Galilee Rd.Big Pool, MD 21711 Rusle Reed sister in law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition May 79, Smithsburg, MD Smithsburg Crematory 2009 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Importent: If eny Injury or once. 22. Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 402000 ARTERY DISEASE WITH Immediate Cause (Final Advanced CORONARY **Physician** disease or condition resulting in death) /Medical Examiner FAILLURB DIABETES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit CADVANCED RENAL INSUFFICIENCY Box 68760. Physician/Medical EPYPHERAL IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? signed t Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No HUPERTENSION certificate hes been si rector, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? HYPOTAYRO IDISM 24a. Was an autopsy performed 2010 1 TYes 2 1 No Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) Hospital: 2 1 Yes 2 ₩No 1 Inpatient 2 ER/Outpatient 3 DOA this After this funeral of 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier D0066751 awance 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 130 W. HIGH ST. HANCOCK HD 21750 HORNICK 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Jak Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	State of Mary	-	epartment of H C <i>ertificate of L</i>		and Mental H	/giene Reg. No.	2009	17695
	Physicia	n	1. Decedent's Name (First, Middle, Last)	_			2. Date of D Month	eath 13ay	200g	3. Time of Death 8:10 A. M
	/Medica	al .	Harriette Miriam Reize	nstein	4b. City, Town, or	L ocation of	May		unty of Death	
	Examine	er	4a. Facility Name (If not institution, give street and number) Renaissance Gardens		Silver				ince Ge	
W-8-4	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Months Davs	If Under 2	24 Hrs. 8. Date of B Min. (Month, L	irth 20, Yea <i>r</i>) 20, 192	9. Birthr	olace (State or Foreign
	Director		102-36-1596 1	86 Y	rs.		Feb.	20, 192	23 Per	insylvania
	/land			0c. City, Town	or Location				1	10d. Inside City Limits
	Ba-f st	ctor	Maryland Prince Georges	Silver	Spring					1x Yes 2 No
	with th	Dire	10e. Street and Number	4	10f. Zip Code 209	04			of What Cour	ntry?
DCS	ns 23	Funeral Director	3160 Gracefield Road, # 3306		13. Was Decedent of H		gin? (Specify Yes or N	!	Race - Americ	
980	filed within 72 hours after death with the Maryland Hygiene. kther than "natural", or items 23a or 28a-f show snt, tre Madical Examinat must be notified at	þ	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 1 Never Married 1 Never Nev		1 ☐ Yes 2 X No	Specify:	, Puerto Hican, etc.)		Black, White, ecify: Wh i	
21215-0036	72 hot	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. I	Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	ation during most	of working	16b. Kind	of Business/In	ndustry
121	vithin and the within	du	Elementary/Secondary (0-12) College (1-4or 5+) 1 Year	ı	life. DO NOT use retired Homemaker	d)		Own	n Home	
d 2	filled v I Hygie other i ent, it	Be Co	17. Father's Name (First, Middle, Last)		Тощемихет		r's Name (First, Midd		rname)	
/lan	uld be Mental rrked o	To B	William Polangin				hia Cransf			
Maryland	1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. Jem 27 Is marked other than "natural", or items 23a or 28a-f show ther traumatic event, it a Marical Examinat must be notified at		19a. Informant's Name/Relationship (Type. Print) Lois R. Stenzel - Daughter	19b. 16 .	Mailing Address (Street 2–31 9th Av	and Numbe enue ,	Apt. 8-D	ber, City or To Whites	tone,	p Code) New York 11357
Baltimore,	of		20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation 3 ♣ Removal from State	20b. Place of I cemetery	Disposition (Name of , crematory or other place	ce)	Date		tion - City or T	
Ë	∴ Pa tπer tant jury		4 □ Donation 5 □ Other (Specify)		t Lebanon		5-17-2009			New York
Bal	permit. Departn Importa any inju		21. Signature of Funeral Service Licensee	# 564	Edward Sa	ger F	uneral Dir Pike, Roc	kville	. Marv	land 20852
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line.	le death. Do n						Approximate Interval Between
Jan.	Physician	1	Immediate Cause (Final disease or condition	tive He	art Failure	!			1	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a continuous according to the continuous according	consequence of	f):					
		ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a of the conditions)	consequence o	f):				-	
B	cuted ansit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or Injury that initiated events							
,00	cate be executed physician and the burial-transit	Ex	resulting in death) Last Due to (or as a d	consequence o	f):					
8760,		dical	d							
o x 6	leath certific attending p	n/Me	IF FEMALE: 23c. If yes, outcome of		•□= · ·			230	d. Date of deli	very
o.B	requires that the death certifi een signed by the attending nould be detached for use as	Physician/Me	A contact A co		3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	у		-	Month	Day Year
~ □ .	that the dened by the a	Phy	Part II. Other significant conditions contributing to death but	not resulting in	the underlying cause giv	en in Part I.	. 23e. Di	d tobacco use	contribute to	the cause of death?
rds,	quires n sign ald be	bg of	hronic Lymphocytic Leukemia				1[∐Yes 2 X	No 3□ Pro	obably 4 🗖 Unknown
Stein Han	w d s	plete					24a. W	topsy	24b. Were aut	topsy findings available completion of cause of
2 E	The laste har page	Com					pe 1 □ Ye	rformed?	death? 1 □ Yes	Y
S.⊤ Vita	Physician; The Is to this certificate harral director, page 2	00	examiner?		— — Oth		of Death (Check on		7011 10	
	y Phys er this eral dii): T 0	27. Manner of Death 28a. Date of Injury	/ 28b. T	ime of 28c. Inju	443 NU	ursing Home 5 Real Real Reservition	e how injury o		orfy)
Iten	Attending ir death. ector: After by the fune	atio	1 Xatural 5 Pending (Month, Day, 2 Accident investigation	Year) In		'K?]Yes 2 □	No			
Aelben Division of	or Atte ter de irecto n by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc.	y - At home, far (Specify)	rm, street, factory, office			n (Street and I Town, State)	Vumber or Ru	iral Route Number,
D	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Physician: To the best of	mv knowledge	death occurred at the t	ime, date a	nd place, and due to	he cause(s) a	.nd manner as	stated.
	ie Hos ne Fun detely	Medical	(Check only one) 2 Medical Examiner: On the basis of each manner state	examination and	d/or investigation, in my	opinion, dea	ath occurred at the tin	ne, date and p	iace, and due	to the cause(s)
	2	Me	29b. Signature and title of certifier	de		se number			signed (Month	
	6		Indew flelder	1		036716		May	y 13, 2	۷ ۷ ۷۶
			30. Name and address of person who completed cause of dea Dr.Andrew Kundrat 3110 Grace	ath (Item 23a) (efield]	Type, Print) Road, Silve	r Spr	ing, Maryl	and 209	904	
	Sta	te	31. Date filed (Month, Day, Year) 32 Registrar	's Signature						
	* Registr	ar	MAY 18 2009 Osteva	, A. x	backet					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death , Day Physician 12.30 AM Earnestine Y. Reese /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Arme H If Under 1 Year | If Under 24 Hrs. BALTIMOPE MARCHANGTON MEDICHE CHENTER SURNIE 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 21 F **Director** 07/10/1951 225-76-0171 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, It is Medical Examinat must be notified at Director 1 √Yes 2 No DC None Washington 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 4715 Piney Branch Rd NW 20011 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ⊠Yes 2 No 1977— If Yes, Give 1997 Year or Dates: 1991 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 XNo þ Specify: Black 3 Widowed 4 Divorced 1991 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Correctional Officer years Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 George C. Reese Sr. Elizabeth V. Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda Williams/sister 7517 Lemon Tree Ct. Hanover, MD 21076 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glenwood Cemetery 05/16/2009 | Washington DC 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licensee 23a. Part Venter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4217 9th St NW Washington DC 20011 Approximate Interval Between Onset and Death immediate Cause (Final **Physician** /Medicai resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 **N**o 2 🗆 No 1 □Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🗌 Homicide

P.O. Division of Vital Records, Notice negrees after death,
Within 24 hours after death,
To the Funeral Director: Af

> State Registrar

2

Medical

29a, Certifier

(Check only one)

31. Date filed (Month, Day,

ture and title of certifier

ne and address of person w

vabo

completed cause of death (Item 23a) (Type, Print

32. Registrar's Signature

l 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Glen Burne

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 21 05 09 1805 Gladys Louise Seeders /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Allegany WMHS-Braddock Campus Cumber land Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours Months Days 1 □ M 2 🕱 F 232-72-9805 75 Feb.16,1934 WV Director Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State show d other than "natural", or items 23a or 28a-f shovevent, it e Madical Examiner must be notified at 1 ☐ Yes 2 🔀 No Director WVMineral Fort Ashby 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 26719 USA Funeral HC-86 Box 49 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Completed by White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withir nent of Health and Mental Hygiene. ant: If item 27 is marked other than School. Cook 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gertrude Haines 2 Homer J. Hott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) George S. Seeders (husband) HC-86 Box 49 Fort Ashby, WV 26719 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 5/25/09 Fort Ashby, WV 4 Donation 5 Dother (Specify) Fort Ashby Cemetery 22. Name and Address of Facility McKee Funeral Home 21. Signature Funeral Service Lie 115 E. Birch Lane Romney, WV 26757 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Mefa 5/2/h Physician Carcinoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ner Exami and burial-tra Due to (or as a consequence of): attending physician for use as the buria Box 68760 pe Physician/Medical certificate IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) P.O. ☐Yes 2 ☐NO the detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 2 100 2 No certificate 1 ☐ Yes 1 Yes Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certificately filled in by the funeral director, p. 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certification 26,2009 D36766

State Registrar

Vikramaditu G 31. Date filed (Month, Day, Year) JUN 02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SETON DRIVE Camberland, Md 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar AMEND#17perFH, 5/18/09, BMWMDGo Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month 0530 AM 05 200 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Hospital Baltimore Harbor 8. Date of Birth (Month, Day, Year) 05/06/1945 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours CM 1 XM 2 □ F 64 **2**12-44-9920 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 XYes 2 □ No Baltimore City MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21214 USA 1 West Conway Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1□Yes 2XNo Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) N/A Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Schroll James James Schoi Elizabeth Murk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2900 Sollers Pt. Rd., Dundalk, MD 21222 Denise Tice / Niece 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 20a. Method of Disposition W. Arundel Crematory 05/16/2009 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rendon-Bailey Funeral Home, PA 21. Signature of Funeral Service Licensee 2818 E. Baltimore St., Baltimore, MD 21224 MO145-2 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final resulting in death)

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be resisted.

Baltimore, Maryland 21215-0036

/Medical

Funeral Director

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Completed

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Be Completed by Physician/Medical Examine attending p signed by the a Medical Certification: To Director; d in by the within 24 hours aft

To the Funeral Di

completely filled in

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760.

2

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that nitiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	nær
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions con	ntributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1
25. Was case referred to medical examiner?		ath (Check only one)
1 Yes 2 No	lospital: 1 Nursing I DOA Other: 4 Nursing I	fome 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 Matural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? M 28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	sician: To the best of my knowledge, death occurred at the time, date and place. ner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	

State Registrar

31. Date filed (Month, Day Year)

29b. Signature and title of certifier

Xiaobing

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signat

29c. License number Les 000 / 29d. Date signed (Month, Day, Year)

Baltimore, MD 21225 Hanover St

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	•		ficate of L			leg. No.	200	17699
	Physicia	an	1. Decedent's Name (First, Middle, Last,					-	2. Date of Dea Month	th Day		3. Time of Death
-	/Medic	al	Eleanor Lillian S				h City Town or	Location of Death	MAY		County of Deat	
	Examin	er	4a. Facility Name (If not institution, give	ALDICAL	Posts	_ 4	. City, Town, or	2/15hum	t	40.	Hicon	
	Funeral		Social Security Number 6. Security Number	7. Age	(In yrs. last birt		If Under 1 Year Months Days	If Under 24 Hrs. Hour Min.	8. Date of Birth (Month, Day 7/28/19	Year)		hplace (State or Foreign
	Director		218-82-0314]M 2⊠F	48	rs. '	violitio Buyo	, iodia	7/28/19	60		MD
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Loca	tion					10d. Inside City Limits
	Mary a-f sh	tor	MD Worcest	er	Snov	v Hi	11					1 ☐ Yes 2 X No
	or 28,	Direc	10e. Street and Number				10f. Zip Code		1		izen of What Co	untry?
	s 23a	Funeral Director	216 W. Federal St			140.14	2186				SA	vison ledine
	item item	-une	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No		If Y	es, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		14. Race - Ame Black, White	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygtene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, Ire l'adical Expriner must be ruiffied at	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 []Yes 2. XTNo	Specify:			Specify:	white
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d 2	2 should be filed within and Mental Hygiene. is marked other than aumatic event, Ire M		17. Father's Name (First, Middle, Last)		<u> </u>	1101	llelliakei	18. Mother's Nam	ne (First, Middle,			
'lan	Aental Aental rked o	To Be	Leroy King					Elean	or Zufal	1		
Maryland	2 short and 1 is ma	_	19a. Informant's Name/Relationship (7)	rpe. Print)		-		and Number or Ru				Zip Code)
	and Health m 27 her tr		Charles E. Schmid	t / husbar				11 St., S	now Hill		D 21863 ocation - City or	Town State
وتو	0		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ F				ion (Name of tory or other plac em. Park	se) 5/22	/2009		kesvill	
Baltimore,	+ + + -		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens		Lakevie		Name and Addre	1 1	urbage F		-	
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). B	e death	Physician/	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth : 4 ☐ Pregnant at 9 ☐ Unknown	time of death		Other (specify) _				Month	Day Year
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	Hospi 24 hou Funer tely fill	Medical		sician: To the best of iner: On the basis of	examination an							
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Med	29b. Signature and title of certifier	and manner sta			29c. Licens	se number		29d. Da	ate signed (Mon.	th, Day, Year)
	,- >F 0		Van				H00	64534		51	16/09	
	enin		30. Name and address of person who c	ompleted cause of de	eath (Item 23a)	(Type, Pr	int)	10	0/ // ***	-		
	BAQ	to.	NICOLUL FULQUE 31. Date filed (Month, Day, Year)	M.O.	100 &	CAL	SMOII -	01. 54	111SBUM	MO		
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

			For State Registrar	State of Ivia	•	epartment of r Certificate of			leg. No. 🤈	nna	17700
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	/Media	al	Margaret 4a. Facility Name (If not institution, give		<u>Z</u>	Ab City Town o	r Location of Death	5		nty of Death	0015 a [™]
ue'	Examir	er	Dove House	street and numbery		Westmi				Carro	11
	Funeral Director			ex □ M 2 X F	e (In yrs. last birth	day) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day		9. Birthp Cour	place (State or Foreign ntry) MD
	and ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				1	Od. Inside City Limits
	Maryl a-f sho	tor	MD Carro	511	Taney	town					1 XYes 2 ☐ No
	or 28	Direc	10e. Street and Number	.,		10f. Zip Code	_			of What Cour	ntry?
	s 23a	Funeral Director	8 Kings Court	12. Was Decedent B	Ever in II C	2178		rify Ves or No-		SA Race - Americ	can Indian
Maryland 21215-0036	s within 72 hours after death with the Maryland giene. r than "natural", or items 23a or 28a-f show the Medical Examiner i ust be northed at	þ	11. Marital Status 1 □ Never Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1	lo	13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	an, Mexican, Puerto R	lican, etc.)		Black, White, or white, whi	etc.
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pu	othe ent,	Be C	17. Father's Name (First, Middle, Last)			11111116 111	18. Mother's Name		Maiden Surr	name)	
ylaı		인	David Yea		ı			ne Nu			
Mar	S S S		19a. Informant's Name/Relationship (Type. Print)		Mailing Address <i>(Street</i> 250 Baby 1			•		21787
	s 1 and 2 of Health item 27 other tr		20a. Method of Disposition	o-in-Law	20h Place of I	Disposition (Name of	F / 0 Pe		20c. Location	on - City or To	own, State
E I			1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State /)	Trinit	y Luther a	5/20 in Cemete	ry	Tane	ytown	, MD
Baltimore,	permit. Page Department of Important: If eny Injury or once.		21. Signature of Funeral Service Licer	1 delle	egr.	22. Name and Addres	F.H. 3			173 e. Li	ttlestown
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	tificate be executed ig physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of)•					
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tal	10 11	Be Co	25. Was case referred to medical		·		26. Place of Death	1	2 ☑ No ne)	1 ☐ Yes	2 🗖 No
<u>_</u>	Physician: this certific	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	ent 2 ER/Out	patient 3 DOA Oth	her: 4 \(\sum \) Nursing Hom			Other (Speci	MENT HOVE
Division of Vital Records,	ing Pl	on:	27. Man⊓ Death 1 Natural 5 Pending	28a. Date of Inju (Month, Date	ry 28b. Ti y, Year) In	ury Wo	rk?	8d. Describe h	now injury oc	curred	
isio	Attending r death. sctor: After by the fune	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		ırv - At home, farı	M 1 C	Yes 2□No	8f. Location /S	Street and No	umber or Run	al Route Number,
<u>≤</u>	al or A s after Il Dire	Certification:	4 ☐ Homicide determined	building, etc	. (Specify)	.,,,		City or Tou	vn, State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical (f examination and	death occurred at the t /or investigation, in my					
	To the vithin 2 To the complex	Σ	29b. Signature and the of certifier	Mule	r Mr	29c. Licen:	se number 5392	_ (29d. Date si	gned (Month,	Day, Year)
	0 1		30. Name and address of person who	completed cause of d	eath (Item 23a) (T	Type, Print)	Veh. idea	120	1150		,
	Sta	ite	31. Date filed (Month, Day, Year)	3'	ar's Signature	D CHECK ()	COUNING	, 100	101		
	Registi	ar	MAY 19	2009 Ken	we A.	parks					
DII	4411 47 D 4/0	001				•					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Gilbert Leroy Schmidt 2009 MAY 1a /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** GLEN BURNIE DALTIMORE U ANNE ARUNDEL)AS HINGTON MEDICAL LENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4/2/1918 Social Security Number 6. Sex Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1√2 M 2□ F Baltimore, MD Director 212-07-1366 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Department of Health and Mental Hygiene.

In proportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Mudical Evantiner must be notified at once. 1 ☐Yes 2 ☑ No Director MD Anne Arundel Millersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 813 Cedar Croft Drive 21108 Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status orces: 2 No WWII Black, White, etc. 1 ∏Yes 2 ltXes, Give 1 Never Married 2 Married White 1 □Yes 2X No Specify: Completed by 3 XXVidowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Engineer Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Schmidt Cassell F. Lula Mae Henry ပ 19a. Informant's Name/Relationally days aughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5016 Tothill Drive Olney,MD 20832 Lynn Michelle Boykin Steeley 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State Baldwin Memorial 5/18/09 Millersville,MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funday Service Licenset 22. Name and Address of Facility Hardesty Funeral Home P.A. Jan 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** NESPILATORY DISTRESS SYMOTOME Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (of as a colis attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) s been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Onknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performe 1 ☐ Yes 2 No 1 ☐ Yes 2 NO Be

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, certificate has b director, neral Director: / e Funeral

Baltimore, Maryland 21215-0036

SCHMIDT, GILBERT

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Depatient 2 ER/Outpatient 3 DOA 27. Man or of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29b. Signature and title of certifier

Certification: To

Medical

31. Date filed (Month, Day,

30. Name and address of person w

WASHINGPA Registrar's Signatu

completed cause of death (Item 23a) (Type, Print)

MAY 12, 2009

Registrar DHMH 17 Rev 1/2001

			For State	State of Ma	aryland / [Department Certificate					000	
			Registrar 1. Decedent's Name (First, Middle, Las	:t)		Certificate	UI Dea		2. Date of Dea	th 2	009	3. Time of Death
	Physici		ALLAN JEREMIAH S		S]	Month MAY	12	Year 2009	2:00 PM
war.	/Medio Examin		4a. Facility Name (If not institution, give	street and number)			wn, or Locati	ion of Death			unty of Death	
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н	Funeral Director		5. Social Security Number 6. Security Number 1	ex 7. Age OXIM 2□F	e (In yrs. last bir 79		Days Hou	irs Min.	8. Date of Birtl (Month, Day NOV • 4	Year)	MAR	nplace (State or Foreign untry) YLAND
Ţ	0		Usual Residence of Decedent									
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-0036	or it	by Fu	1 ☐ Never Married 2 📉 Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 □ N If Yes, Gireo 4 Year or Dates		1 □ Yes 2			,		ecify: WH	
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and	mould be lifed withing Mental Hygiene. marked other than matic event, it will	Be	17. Father's Name (First, Middle, Last) EUGENE PERRY SIPE					other's Name NA MAR			rname)	
Maryland		ပု	19a. Informant's Name/Relationship (196	. Mailing Address (wn, State, Z	(ip Code)
	and 2 saith ar alth ar 27 is er trau		ELIZABETH BOFFE	N SIPES/WI	FE 2	02 FIRST	STREET	CHES!	TER, MI	2161	9	
go ₊	Jes la tof Hea If item or othe		20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place o cemete	f Disposition (Name ry, crematory or oth	of er place)	Da		20c. Locat	ion - City or	Town, State
tim E	the rages the rages the rages of the rages o	V)	4 Donation 5 □ Other (Specify	()	BROADO	REEK CEMI		MAY 1			ENSVIL	
Bal	permit. rages Department of Important: If it any injury or o		21. Signature of Funeral Service Licen	#7/L	•	FELLOWS 106 SHA	HELE MROCK	ENBEIN ROAD,	& NEWN	IAM FU	NERAL 21619	HOME, P.A.
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that caused one cause on each lir	I the death. Do	not enter the mode	of dying, suc	h as cardiac or	respiratory ar	rest,		Approximate Interval Between
	hysician	4 8	Immediate Cause (Final disease or condition		TORY FA							Onset and Death 2 MONTHS
	/Medical xaminer		resulting in death)		a consequence	of): RT FAILUR	F					7 YEARS
		je l	Sequentially list conditions,	b	B. BUNDAYUSTON	-16	<u> </u>					/ IEARS
ite Delita	nd ransit	Examiner	and the second of the second o	GENERAL	IZED AT	HEROSCLER	OSIS					15 YEARS
8760,	physician and the buriat-transit	Ä	resulting in death) Last	,	a consequence S MELLI	•						20 YEARS
	physics the b	dical		, d	O FILLEL	105						ZU TEARS
Box 6	anding use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		- C =				230	i. Date of del	ivery
Ö jeg	ne atte	Physician/M	in the past 12 months? 1 □Yes 2 □No	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death t time of death	n 3 ☐ Ectopic pre 5 ☐ Other (spe					Month	Day Year
P.O.	d by the	Phy	9 ☐ Unknown Part II. Other significant conditions c		ut not reculting i	n the underlying cal	see given in E	Port I	23e Did to	obacco use	contribute to	the cause of death?
of Vital Records, P.O	requires that the beautifications is been signed by the attending I should be detached for use as	ρ	RENAL FAILURE	ontributing to death be	at not resulting i	in the underlying cat	ase given in r	art i.				obably 4 📉 Unknown
CO	07 01	Completed							24a. Was		24b. Were au	itopsy findings available
A	ate has	mo							autop perfo 1 □ Yes	rmed?	death?	completion of cause of 2 □No
of Vita	r this certificate har ral director, page 2	Be (25. Was case referred to medical examiner?	Hasaitala				Place of Death	(Check only o	ne)		
of	ruys rthis raldir	ا ا	1 ☐ Yes 2 🗷 No 27. Manner of Death	Hospital: 1 ☐ Inpatie		utpatient 3 DOA		☐ Nursing Hon	ne 5 X Resident			cify)
/ision	uth. r: After thi e funeral o	atior	1 Natural 5 Pending 2 Accident investigation	(Month, Da	ıy, Year)	Injury M	c. Injury at Work? 1 □Yes	2 □No				
	ter des irector	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined	20e. Place of Inju	ury - At home, fa c. <i>(Specify)</i>	arm, street, factory,	office	2	8f. Location (S City or Tov		Number or Ru	ural Route Number,
	ours al eral D filled i		29a, Certifier 1 Tertifying Ph	nysician: To the best	of my knowleda	e death occurred a	t the time da	ate and place, a	and due to the	cause(s) ai	nd manner a	s stated.
Div	vithin 24 hours after deat To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Exam	miner: On the basis o and manner sta	of examination a	nd/or investigation,	in my opinion	, death occurre	ed at the time,	date and pl	ace, and due	to the cause(s)
Ę	withii To th	Me	29b. Signature and title of certifier	01/		29c.	License num	ber				h, Day, Year)
6	(+1		I limothy	L. Vices	- In	/	003745	8		MAY	14, 2	009
Ų	MS		30. Name and address of person who TIMOTHY J. KEAY	-		(Type, Print) EENE STRE	ET, BA	LTIMORI	E, MD 2	1201-	1595	
-2.	Sta Registr		31. Date filed (Month, Day, Year) MAY 14	2009 32. Registr	rar's Signature	park	/					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Julie Ann Simmons Moy 15 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Cambridge Dorche. Dorchester General Hospita If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year, **Funeral** Days Min. 1 □ M 2 🖸 F Yrs. 219-42-8562 63 July 5, 1945 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location an "natural", or items 23a or 28a-f show Medical Examiner must be notified at MD Dorchester East New Market 1x Yes 2 No Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10 Railroad Avenue 21631 USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: white ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) line worker electronics the 12 permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygic Important: If Item 27 is marked other any Injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel James Dail Sr. Nellie Wilson 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Howard Simmons husband P. O. Box 357, East New Market, MD 21631 20b. Place of Disposition (Name of cemetery, crematory or other place) Date. 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) East New Market Cem. 5/20/09 East New Market, MD 22. Name and Address of Facility 21. Signature fill Funeral Service Licensee Thomas Funeral Home P.A. Kon 700 Locust St., Cambridge, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Asteriosclerotic Cardiovascular disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1☐ Yes 2☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Remore 1 Yes 2 → 10 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EN/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 → No 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

within 2. 2

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760,

State

Medical

29a. Certifier

29b. Signature and title of certifier

JOMAN

Registrar

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THANWY

MD

503

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D47924

29d. Date signed (Month, Day, Year)

171)

5.16.09

CAMBRIDGE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** $a^{\,\text{M}}$ ya May 14, 2009 6:35 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Shady Grove Hospital Rockville Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y April 5, 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Year. 1 □ M 2 🖬 F Yrs. 217-69-2606 Kazakhstan Director 61 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits 28a-f show is marked other than "natural", or items 23a or 28a-f shov aumatic event, the Madical Examinar than the confined at 1 ☐ Yes 2 🛣 No Director Montgomery Village Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 19505 Gallatin Court 20866 Kazakhstan within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ∐Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🛛 No <u></u> Specify Specify: 3 XWidowed 4 Divorced Asian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unobtainable Unobtainable permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ San Khen 01ga Khwan Tsoy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19505 Gallatin Court; Montgomery Village, MD 20886 Denis Tskhay 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 5/18/2009 Brentwood, MD 21. Signature of Funeral Service Licensee Simple Tribute 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the diserce, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, by heart failur. List only one cause on each line. Immediate Cause (Final **Physician** myocardial disease or condition resulting in death) minuk /Medical Due to (or as a consequence of): Examiner Atheroscherotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and s the burial-transit be executed Exami Due to (or as a consequence of) Box 68760, Physician/Medical attending p for use as use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) signed by the a d be detached f Tyes 2 No Ö 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an cate has b page 2 s autopsy performed Yes 2 No this certificate 1 □ Yes or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 After thi funeral 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated

DHMH 17 Rev 1/2001

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Janathan Wenk - 9901

MAY 18 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

Registrar's Signature

29c. License number

X058025

Center Drive, Rockville, Md

29d. Date signed (Month, Day, Year)

2009

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Baltimore, Maryland 21215-0036

Ph /N Ex

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

		For State	ricas	State o	f Marylan	d / Depa	artment	of H	ealth a				-cg151	0.		
		Registrar	(First Middle	l act)		Cei	rtificate	OT L	eatn		2. Date of De	Reg. No.	20	9	3 Time of	7.05
Physicia	an	1. Decedent's Name			10						Month 5	Day	20 20	ear 09	12:01	Рм
/Medic		4a. Facility Name (If		Torpey, J			4b. City, 7	own, or	Location of	of Death			County of		12.01	•
Examin	eı	16 Drift		_	,				Pines			V	Vorce	ste	r	
Funeral Director		5. Social Security No. 175–30–69	38	6. Sex 1 X M 2 □ F	7. Age (In yrs. 69	last birthday) Yrs.	If Under	Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Bir (Month, Di 3/6/19	rth ay, Year) 40	9	. Birthp Coun	lace (State o try)	r Foreign
m w		Usual Residence of 10a. State	Decedent 10b. County		10c. Cit	y, Town or Lo	cation							1	0d. Inside Ci	ty Limits
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r 28a	Funeral Director	10e. Street and Nun		5001		- OCCUII	10f. Zip					10g. Citiz	zen of Wha	at Coun	try?	
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tems	nue	11. Marital Status		Armed Fo		S. 13.	Was Dec <i>e</i> de If Yes, spec	nt of His fy Cubar	spanic Ori n, Mexicar	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	o- 1	4. Race - Black,	Americ White, 6		
rs afte	by F	1 Never Marrie		ed 1 ∏Yes If Yes, Gi Year or D	ve		1 □Yes 2	□X No	Specify:				Specify:	wh	ite	
2 hour	ted		15. Decedent	's Education	4100.	16a. Dece	dent's Usua	Occupa	ıtion			16b. Kir	nd of Busir	ness/Ind	dustry	
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led wi lygier her th	ပ်					Ріре	Cover		40 Mada	ula Nama	(First, Middle	1	ulati	on		
2 should be filed within 72 hours after death with the Maryland i and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	Be	17. Father's Name (Ragen	, Maluell	<i>surname)</i>			
shoulk nd Me mark mati	욘	19a. Informant's Na				19b. Mailir	ng Address	Street a			A Route Numb	per, City or	Town, St	ate, Zip	Code)	
and 2 salth a salth a 27 is er tra		Patricia	A. To	rpey / wi	fe	16	Drif	twoo	d Lar	ne, C	cean P	ines	, MD	218	11	
of He		20a. Method of Disp		3 ☐ Removal from		Place of Dispo emetery, crer					ate		cation - Ci			
: Pag tment tant: I		4 ☐ Donation	5 ☐ Other (Sp	ecify)	St.						2/2009	1			ia, PA	
permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu	neral Service L	icensee nation			2. Name and 108 W			טנ	ırbage Berlin,	Funer	ral H 21811	ome		
		23a. Part Fenter th shook, or hear	ne disease, or or rt failure. List o	complications that conly one cause on e	aused the deat	h. Do not ent	ter the mode	of dying	g, such as	cardiac	or respiratory	arrest,			Approximate Interval Bet Onset and I	ween
Physician		Immediate Cause (disease or condition resulting in death)		a	AJ	5 < V	D							2	12a	-
/Medical Examiner		resulting in death)		Due to	(or as a conseq	uence of):								1		
	ier	Sequentially list cor if any, leading to im- cause. Enter Under Cause (Disease or	nditions, mediate	b	(or as a conseq	uence of):								-		-
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be executed ician and burial-transit		resulting in death) L	_ast	Due to	(or as a conseq	uence of):										
cate t	dical			d							4					
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an: T	Be Co	25. Was case refer	red to medical	1					26. Place	of Death	1 ☐ Yes h (Check only		1 1	_ Yes	2 No	
nysici nis cer direc		examiner? 1 ☐ Yes 2 🗗	No	Hospital: 1 🗆	Inpatient 2	ER/Outpatie	nt 3 🗆 D0	Othe			me 5 Res		6 ☐ Other	(Speci	(y)	
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To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Medical (29a. Certifier (Check only one)	1 Certifyin 2 Medical	g Physician: To the Examiner: On the b	e best of my kno pasis of examina oner stated.	owledge, deat ation and/or ir	th occurred ovestigation	at the tin	ne, date a pinion, dea	nd place, ath occur	and due to th red at the time	e cause(s) e, date and	and man place, an	ner as : d due t	stated. o the cause(s	5)
To tll withi	Ň	29b. Signature and	title of certifier	Mill	jeo,	4.0.	290	License	number	90	4	29d. Dat	e signed	Month,	Day, Year)	
BAG		30. Name and addr	ess of person													
Sta	te	31. Date filed (Mon	th, Day, Year)	32. F	Registrar's Signa	ature	,									
Registr			MAY 18	2009	nun	B. A	arke									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year Katherine Toth /Medical May 4 2009 6:30p 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3261 Oak Street Carroll Manchester If Under 1 Year | If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2√□ F Director 218-28-5584 76 10/13/1932 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director Carroll Manchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3261 Oak Street 21102 USA "natural", or items 23a Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 € No Specify. þ Specify. white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Avis Rent A Car bookkeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Laura (unknown) John Ganskop 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Toth, husband 3261 Oak Street, Manchester, Md. 21102 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Cremation 5/16/2009 Hampstead, Md. Carroll 21. Signature of Funeral Service License 22. Name and Address of Facility Eline Funeral Home M00741 934 S. Main St., Hampstead, Md. Lemmer 21074 Mande 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each #ne. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MR disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner RR Sequentially list conditions Physician/Medical Examiner Duc to (or as a nonsequ cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last death certificate be executed burial-trar Due to (or as a consequence of) Box 68760. physician the as attending IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 No P.0. ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by sign 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed res 2 certificate 1□ Yes Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 🗌 Yes 25700 Other: 4 ☐ Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To 5 Residence 6 □Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural Division or Attending 5 Pending investigation after death. 2 Accident 1 TYes 2 No filled in by the 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aff To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WIL D0051816

6 State Registrar

30. Name and address of person

Day, Year,

31. Date filed (Month,

impleted cause of death (Item 23a) (Type, Print)

3

Mancheste

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 13, **Physician** 2009 Henry Lorain Thomas May 3:15 рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pinetree Assisted Living Bryans Road Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Oct. 20, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Vear) 1915 Washington D.C. Months Days 1 🔀 M 2□ F Hours Min. 93 220-38-0957 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes X□No Director Maryland Charles Indian Head 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4590 Hawthorne Road 20640 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Completed by Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineer 12 U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Edwin Thomas Agnes Maude Cox 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Craig J. Lockwood 4570 Hawthorne Road, Indian Head, Md. 20640 Executor 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State May 14, 2009 Metropolitan Funeral Service 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 22. Name and Address of Facility Williams Funeral Home, P.A. 21. Signature of Funeral Bervio M00668 4270 Hawthorne Rd., Indian Head, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause T disease or condition resulting in death) Final Almoasrula Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 □Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending (Month, Day, Year) investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier

The law requires that the death certificate be executed physician and the burial-transit Box 68760. sate has been signed by the attending page 2 should be detached for use as P.0. Records, Vital Physician: of this After t Hospital or Attending Division within 24 hours after death.

To the Funeral Director: A completely filled in by the fu To the within 2

Funeral

Director

s 23a or 28a-f show

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant of Heatth and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o any injury or other traumatic event, the "section Exam any injury or other traumatic event, the section Exam any once.

Physician /Medical Examiner

altimore, Maryland 21215-0036

State Registrar

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29b. Signature and title of

race 31. Date filed (Month, Day, Year)

MAY 18 2009

DHMH 17 Rev 1/2001

Old Line Ctr

and manner stated

32. Régistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Ste 302 Waldo

29d. Date signed (Month, Day, Year)

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Divis To the Hospital or Atte within 24 hours after de To the Funeral Directe completely filled in by it		29a. Certifier	1 Certify	ing Phys	ician: To th	he best	of my kn	owledge,	death occ	urred at the	e time, da	ate and plac	ce, an	d due to the	he cause	e(s) and m	anner as	stated.	
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	ate	31. Date filed (Mor	nth, Day, Year	7)	32.	Registra	ar's Sign	ature	60.0	1		nber 557 inaud					-		
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		l- For State Registrar	Certificate c	of Health and Mental H Inf Death	Reg.	No.	000 177					
Physici ledical Exam	an/	1. Decedent's Name (First, Middle,Last) Timothy Wayne Tipton			2. Date of Death Month D May 20, 200	ay Year 9	3 Jime of Death / 0837 hrs					
		4a. Facility Name (if not institution, give street and number) 50 Appeal Lane Creston Lane		4b. City, Town, or Location of Death Solomon		4c. County of Deal	<u>-1</u>					
Funeral	Ħ		e (In yrs. last birthday)	If Under 1 Year If Under 24Hrs	. 8. Date of Birth(MM/DD/YYYY) 9. Bi	rthplace (State or					
Director		577-92-0107 1 _X M 2 F	51 _{YI}	Months Days Hours Min	January	7,1958 c	^{gn} ₩ars)hington D					
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loca	ation			10d. Inside City Limits					
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ith the Maryland 23a or 28a-f sho	Director	10e. Street and Number 50 Creston Lane		10f. Zip Code 20688	log	Citizen of What Co	untry?					
215-0036 be filed within 72 hours after death with the Maryland mall Hygiens Head other than "natural", or items 23a or 28a-18th ent, the Medical Examiner must be notified at once		11. Marital Status 12. Was Decedent		/as Decedent of Hispanic Origin? (Single Yes, specify Cuban, Mexican, Puerto			rican Indian, Black,					
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21215-0036 Uld be filed within 72 hours after Mandal Hygiens Amandal Hygiens marked other than "natural", e event, the Medical Examiner.	ed by	15. Decedent's Education (Specify only highest grade com	during	ent's Usual Occupation (Give kind of most of working life. DO NOT use ret		6b. Kind of Business	s/Industry					
036 Ithin 72 ne. • than "	Completed	Elementary/Secondary (0-12) College (1-4 or 5		roundskeeper		Lawn C	are					
MD 21215-0036 nd 2 should be filed within 7 th and Mental Hygiene. m 27 is marked other than anumatic event, the Medica	e Cor	17. Father's Name (First, Middle, Last) Roy McKinley Tipton			e (First, Middle, Ma	iden Surname)						
T. p 0 % 5	To Be	19a. Informant's Name/Relationship (Type, Print)	· ·	Patsy Li ng Address (Street and Number or	Rural Route Numb							
		Roy Tipton/Father 20a. Method of Disposition		Klovstad Dr. For		gton, MD 2						
imore, MI Pages 1 and 2 s nent of Health a ant: If item 27 or other traum		1 X Burial 2 Cremation 3 Removal from Sta	ate crematory or o	other place)	26/09	Port Repu	blic.MD					
Baltimore, permit. Pages 1 at Department of Hec Important: If ite injury or other tr		4 Donation 5 Other Specify: 21. Signature of Juneral Service Licensee		Name and Address of Facility AREHART —ECHOLS		OME D A						
Physician		23a. Part I. Enter the disease, of complications that caused	the death. Do not enter	211 St Mary s At	respiratory arres	ata MD t, shock, or heart	20646 Approximate Interval Between Onset and					
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tox 68760, leath certificate be executed attending physician and for use as the burial - transit	n/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcor		Fetal death 3 Ectopic pregn	ancy	23d. Date of delive Month	ery Day Year					
Box 6 e death cert the attendii	Physician/N	past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown	time of dooth	Other (Specify)								
Division of Vital Records, P.O. Box the Ilospital or Attending Physician: The law requires that the death Air A hours after death. The Funeral Director: After this certificate has been signed by the are appliedly filled in by the funeral director, page 2 should be detached for us		Part II. Other significant conditions contributing to death		e underlying cause given in Part I.	-		to the cause of death?					
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Division of ' Septial or Attending Ph hours after death, meral Director: After t	Certification:	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or or Town, State)										
Ilospital 24 hours a Funeral		1 298. Certifier a la sur a la										
To the Hos within 24 h To the Fur completely	Medical	ona) 2 Medical Examiner: On the basis of examiner and manner stated. 29b. Signature and title of certifier	mination and/or investig	gation, in my opinion, death occurred 29c. License number	at the time, date a	nd place, and due to 29d. Date signed (I						
	_	Aug. Signalare and the or certifier		O.C.M.E.		May 21, 2009						
(30. Name and address of person who completed cause of c		Street Beltimore MD 0400	l							
DB		Ana Rubio MD. Assistant Medical Exam 31. Date filed (Month, Day Year) 7 2009 32. Registra	niner 111 Penn	Street, Baltimore, MD 2120								

DHMH 17 Rev 1/2001

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1	For Amend Item 24a,29d per Werb.,8	Certificate of Death		
Physicia /Medic	ın	Decedent's Name (First, Middle, Last) CLAUDIA HERSCHEL WU	IGK	2. Date of Death Month Di 5/17/2	ay Year 3. Time of Death 10:49 A M
Examin		4a. Facility Name (If not institution, give street and number) 5602 ROSS NECK RD.	4b. City, Town, or Location of Death CAMBRIDG		c. County of Death DORCHESTER
Funeral Director		5. Social Security Number 492-09-2047 6. Sex 1 □ M 2 ▼ F 7. Age (In yrs. last birtho	day) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year 12/31/19	9. Birthplace (State or Foreig Country)
Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of DORCHESTER	or Location CAMBRIDGE		10d. Inside City Limit
72 hours after death with the Maryland natural", or items 23a or 28a-f show dicat Exa, it er must be treiffisd at	ral Director	10e. Street and Number 5602 ROSS NECK RD.	10f. Zip Code 21613		USA 14. Race - American Indian,
urs after de al", or item	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ▼Wildowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 XNo Specify:	Rican, etc.)	Black, White, etc. Specify: WHITE
within ene. than "	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4	recedent's Usual Occupation Give kind of work done during most of work ife. DO NOT use retired) ARTIST / HOMEMAKE	ing	Kind of Business/Industry OWN HOME
should be filed and Mental Hygis s marked other numatic event, in	To Be Co	17. Father's Name (First, Middle, Last) CLAUDE HERSCHEL	18. Mother's Nam	e (First, Middle, Maide AGNES I	MONOHAN
l and 2 s Health ar Health ar Health ar Ither trau		KASONDRA JANSSON / DAUGHTER	Mailing Address (Street and Number or Rule 134 BRIG CT., II)	IALF MOON B.	
Pages ment o ant: If i ury or		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	Disposition (Name of crematory or other place) E CREMATION CENTER 5/2 22. Name and Address of Facility	1/2009	CAMBRIDGE, MD
permit. Departi Importi any Inji		23a. Part1. Enter the disease, or complications that caused the death. Do no	MID SHORE CREMATION CEN		SON RD., CAMBRIDGE, MD 21 Approximate Interval Between
Chysician pe executed Medical Examiner as the burial-transit	edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of the conditions of the condi	Hun tail	ure	Onset and Death
= 0,6	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 DNo 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
rnystcian; The law requires man the death cer this certificate has been signed by the attendin ral director, page 2 should be detached for use a		Part II. Other significant conditions contributing to death but not resulting in t	cco use contribute to the cause of death? 2 No 3 Probably Unknown		
ifficate has b	e Completed by	25. Was case referred to medical	26. Place of Dea	24a. Was an autopsy performed' 1 □ Yes 2 X	24b. Were autopsy findings availa prior to completion of cause death? No 1 Yes 2 No
to the hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification: To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp 27. Manner of Detth 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined Homicide 4 Homicide Could not be determined	oatient 3 DOA Other: 4 Nursing H me of	ome 5 Residence 28d. Describe how in	and Number or Rural Route Number,
s nospiral or 24 hours afte Funeral Dire etely filled in t		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and	death occurred at the time, date and place //or investigation, in my opinion, death occu	e, and due to the caus	e(s) and manner as stated.
o the reconstruction of the F	Medical	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
20		30. Name and address of person who completed cause of death (Item 23a) (1) Eric T. Widmatk M. J. 32(D	Type, Print) Writhouter Aul Gu	mbridge,	mo 21615
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	all .		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 26,31 per verb 9892,06/02/09dhb
Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) May 24, 2009 9:45 A^{M} White Joseph 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery 9612 Beman Woods Way Potomac If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min. 1 X M 2 □ F 65 2, 1944 New York 113-34-9032 Jan. Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Maryland Montgomery Potomac 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9612 Beman Woods Way 20854 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Specify: White 1 ☐ Yes 2 🗓 No Specify 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Automotic Data Elementary/Secondary (0-12) College (1-4or 5+) Processing Vice President Finance 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph W. White Catherine Durkin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy White (Wife) 9612 Beman Woods Way, Potomac, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Patrick's Cemetery 5/29/09 5 ☐ Other (Specify) 21. Signature of Juneral Service Lice 22. Name and Address of Facility
Finger Lakes Family Funeral Home 45 High St., Geneva, NY 14456 unn 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Renal Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of)

To the Hospital or Attending Physician: The law requires that the death certificate be execute the attending physician and hed for use as the burial-tran Division of Vital Records, P.O. Box 68760 been signed by should be detach rector, page 2 s after death.

I Director: A
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Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examinar must be notified at

Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23 ary or other traumatic event, the Wedical Examination was

permit. Pages 1
Department of H
Important: If ite
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Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

Director

Completed by Funeral

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If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consect d	quence of):	tery D	isease	years	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 Ectopic pre			23d. Date of delivery Month Day Year	
Part II. Other significant conditions co	entributing to death but not res	sulting in the underlying cau	use given in Part I.	23e. Did tobacco	o use contribute to the cause of death? 2 No 3 Probably 4 Unknown	
				24a. Was an autopsy performed?		
25. Was case referred to medical examiner?			26. Place of De	eath (Check only one)		
1 Yes 2 No	Hospital: 4 Nursing Home 5 M Residence 6 Other (Specify)					
27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of lnjury M	ic. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how inj		
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, factory, fy)	office	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier 1\(\bar{\text{L}}\) Certifying Phy one) 2 \(\bar{\text{Medical Exam}}\)	ysician: To the best of my kn iner: On the basis of examin and manner stated.	owledge, death occurred a ation and/or investigation,	at the time, date and placin my opinion, death occ	ce, and due to the cause curred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)	
29h Signature and title of certifier	-1	29c	License number	29d. [Date signed (Month, Day, Year)	

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

38 Name and address of person who completed cause of death (Item 23a) (Type, Print)

parto

29c. License number

MD035829

Rd NW, Washington

29d. Date signed (Month, Day, Year)

05/26/2009

within 24 hours aft

To the Funeral Di

completely filled in

ste vvinte	1- For State Certific	ate of Death	Reg. No. 2009	77			
nysician/ Examine			2. Date of Death Month Day Year May 25, 2009 3. Time of Deat 1140 hrs	tn			
	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death				
	1031 St. Marys Road	Pylesville	Harford				
neral	5. Social Security Number 6. Sex 7. Age (In yrs. last bird	thday) If Under 1 Year If Under 24Hrs Months Days Hours Mir	Country)	r Foreig			
ector	213-52-9443 1 M 2xF 99	Yrs.	11/28/1909 Maryland				
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location	10d. Inside City	y Limits			
	MD Harford Pyles	sville	1 Yes 2	X N			
a or 28a-f sh lified at once Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?				
23a or 28a-f show notified at once.	1031 St. Mary's Road	21132	USA				
Department of return and working register, than "natural", or items 23a or 28a-f sho important. If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified at once injury or other traumatic event, the Medical Examiner must be notified at once injury or other traumatic event, the Medical Examiner Director To Be Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S		ck,			
or items 23	1 Never Married 2 Married Armed Forces? 1 Yes 2 No		White				
miner by	3 X Wildowed 4 Divorced in 16s, Give 16ei or Dates;	1 Yes 2 X No specify: Decedent's Usual Occupation (Give kind of	Specify.				
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r than fedica	. 2	Homemaker	Own Home				
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arked event,			C. Wright Rural Route Number, City or Town, State, Zip Code)				
reath and wentar rygene. Iraumatic event, the Medical Examiner To Be Completed by		280 Main Street, Fel					
item 2	20a. Method of Disposition 20b. Place	of Disposition (Name of cemetery,	Date 20c. Location - City or Town, State				
other If	A Barrar 2 Greination of Removal nonicitate CL M	tory or other place) iary's Cemetery 5/2	29/2009 Pylesville, MD				
portar Iry or	21. Signalune of Funeral Service Vicersee	22. Name and Address of Facility	rylesville, FD				
Import	C'holvert folinsan		ome, Inc., Delta, PA 17314				
ician	23a. Part I. Enter the disease, or complications that caused the death. Do n failure. List only one cause on each line.	ot enter the mode of dying, such as cardiac	or respiratory arrest, shock, or heart Approximate Between On:				
dical niner	Immediate Cause (Final disease a. Hypertensive Atheroscleroti	c Cardiovascular Disease	Death	h			
	or condition resulting in death) Due to (or as a consequence of):						
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ransit	events resulting in death) Last Due to (or as a consequence or): d.						
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			23d. Date of delivery				
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detache	Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of de				
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ficate has been significate has been significated because 2 should be Completed			24a. Was an autopsy performed? 24b. Were autopsy findings a prior to completion of ca death?				
page Dom			1 ✓ Yes 2 No 1 ✓ Yes 2	No			
After this certificate uneral director, page	25. Was case referred to medical examiner?	26.Place of Death (Check Outpatient 3 DOA Other Nurs					
_ E E	1 V Yes 2 No Impatient 2 Erve	Outpatient 3 DOA Oute4 Nurs Time of Injury 28c. Injury at Work?	ing Home 5 Residence 6 ✓ Other: Scene 28d. Describe how injury occurred				
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Director: In by the	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, 1	farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Numb	ber, Cit			
Funeral Director: After teleging the fune fune fune fune fune fune fune fun	3 Suicide 6 Could not be determined (Specify)		or Town, State)				
	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
To the Fur completely	one) 2 Medical Examiner:On the basis of examination and/or and manner stated.						
Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)				
	Card Hallan	O.C.M.E.	May 26, 2009				
0	30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111	Penn Street, Baltimore, MD 212	01				
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	10.52					
Registra	JUN 0 2 2009 Proces A.	posis					
Rev 1/2001	OCWE O	RIGINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 2009 Brian Joseph Whoston May 26 0029 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital Ceci1 E1kton If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1**∑**M 2□ F 222-52-7072 Director Delaware 50 April 29, 1959 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 1 ☐ Yes 2 👿 No Directo New Castle Delaware Newark 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death with in and Mental Hygiene.
Is marked other than "natural", or items 23a or 2 ?7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be re 6 Penfield Drive 19713 United States 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Seal Coating 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David T. Whoston, Sr. Patricia E. Riley 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an item 27 i Patricia E. Whoston/Mother 6 Penfield Drive, Newark, DE 19713 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition May 29, 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) All Saints Cemetery 2009 Wilmington, DE 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, MD 21. Signature of Funeral Service Licensee 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) erdier /Medicai Due to (or as a consequence of): Examiner cerel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of): requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical as attending i IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a Was an has autopsy performed? 1 Yes 2 No Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA ပ this 28a. Date of Injury (Month, Day Year) 28b. Time of To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the funera 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

NAMITA 31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar UNION HOSPITAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2115 WILHELM 2009 GEORGE ALFRED 05 11 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WMHS Braddock Campus Cumberland **Allegany** If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 ★M 2 □ F 220-28-5433 74 11, 1935 WEST VIRGINIA Director JAN. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show Department of Health and Mental Hygiene. Important: or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once. 1 ☐ Yes 2X No Director RIDGELEY WV MINERAL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ROUTE 2, BOX 202 U.S.A. 26753 death v by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2X Married Maryland 21215-0036 1∐Yes 2∭XNo Specify: Specify: WHITE 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FIREMAN FIRE FIGHTING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental MARGARET ELEANORA CLARK JOHN A. WILHELM ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ROUTE 2, BOX 202, RIDGELEY, WV CARLEE WILHELM / WIFE altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State FORT LINCOLN CEMETERY 05/15/2009 BRENTWOOD, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
UPCHURCH FUNERAL HOME, INC
P.O. BOX 1260, FORT ASHBY, 21. Signature of Funeral Service Lic-23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hard failure. List only one cause on each line. INC. 26719 Approximate Interval Between Onset and Death Immediate Cause (Final Physician Myocardi hours +cute disease or condition resulting in death) /Medical Due to (or as a consequence): Examiner Sequentially list conditions, if any, leading to initionate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se's consiquence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a d be detached for Ö 1 □Yes 2 □No 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy perform death? certificate Morbiel 1 ☐Yes 2 ☐ No 1 □Yes of or Attending Physician: after death. To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ 1 € 1 Other: 4 \sum Nursing Home 5 \sum Residence 6 \sub Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) manner stated.

8 nRS

Registrar

r. Vikramadit

31. Date filed (Month, Day, Year)

of certifie

29b. Signature and title



36766

Drive Cumberland, MD

May 12, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2009 8:58 A Elizabeth Ann Warnick May 13, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WMHS-Braddock Campus Cumberland Allegany If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 □ M 2 V□ F Yrs 05/26/1936 72 Massachusetts 232-54-4681 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, I'm Medical Examinar must be notified at 1 XYes 2 No Director MD Cumberland Allegany 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 72 hours after death with 521 Warren Street 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify. þ 3 Widowed 4 ☐ Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Hospital 12 <u>Registered Nurse</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) th and Mental F Wiltison Audrey Varieur Arthur Charles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a Mark K. Warnick / Son 521 Warren Street, Cumberland, MD other Department of Heal Important: If item 2 any injury or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Cumberland Crematory 05/17/2009 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature of Funeral Service Licenses 404 Decatur Street, Cumberland, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Days disease or condition resulting in death) Acute Renal Failure /Medical Due to (or as a consequence of) **Examiner** Days Hypotension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Months Cardiomyopathy burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. attending physician for use as the burial pe Physician/Medical certificate as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Ö □Yes 2 □ No 9 Unknown d be detach ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ Chronic Obstructive Pulmonary Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Diabetes Mellitus has autopsy page 2 certificate of Vital 1∐Yes 2∏XNo Large Cell Tumor Metastatic director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐ Yes 2 X No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. al or Attendi after death. I Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a

To the Funeral I Hospital 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0054411 May 13, 2009 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) This Bever 1/y Calkins M.D., 500 Memorial Avenue, Cumberland, MD 21502 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

		•	for State Registrar	State of Ma	•	epartment of H Certificate of L			2009	17716	
	Physicia							2. Date of Death	D, Day 009 Year	3. Time of Death 12:40 a _M	
	/Medic Examin		4a. Facility Name (If not institution, gi			4b. City, Town, or Silver	Location of Death Spring		4c. County of Death Montgome		
	Funeral Director		5. Social Security Number 6. 2 1 0 - 74 - 7262	Sex 7. Age	(In yrs. last birth 92 Yı	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov • 17	Year) 9. Birth Cou 1916 Ch	place (State or Foreign ntry) ina	
ryland how		_	Usual Residence of Decedent 10a. State							10d. Inside City Limits 1 ☐ Yes 2 No	
Ealtimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumetic event, the Medical Exemination and injury or other traumetic event, the Medical Exemination and process.	the Ma	recto	MD Montgor 10e. Street and Number	пету	311761	10f. Zip Code		11	Og. Citizen of What Cou	ntry?	
	23a or	Funeral Director	9727 Mt.Pisga	n Road #1		20903			Chin	a	
	ours after dearal", or items	þ	11. Marital Status 1 ☐ Never Married 2 🎛 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cuba 1 □Yes 2X No		ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White, Specify:	ican Indian, etc. Asian	
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	uld be fil Aental H rked otl tic ever	To Be	17. Father's Name (First, Middle, Las Yuyi Zhou	7)			18. Mother's Name Chen S		naiden Sumame)		
	and 2 shou salth and N n 27 Is ma ier traume	_	19a. Informant's Name/Relationship Xinnong Tang/		972	Mailing Address (Street of Pisc	gah Rd.#	1502 S	ilver Spr	ing,Md	
	. Pages 1 tment of He tant: If Iten Jury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation, 5 ☐ Other (Special Content of the Conten	()		Disposition (Name of crematory or other place creake Crei	n. 5/15/	2009	20c. Location - City or T Beltsvill	e,Md	
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			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between the disease of the disease on each line.								
	Physician /Medical)r	Immediate Cause (Final disease or condition resulting in death)	a u.	iopulmo	onary arre	est				
	Examiner		Sequentially list conditions,								
cuted nd ransit	ecuted ind transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events	consequence of							
68/60,	tificate be executed g physician and as the burial-transit	cal Ex	resulting in death) Last	Due to (or as a	consequence of):					
	± 5, 6	Physician/Medical	IF FEMALE:						1		
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JS, T	res that signed l		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part pneumonia, urinary tract infection,						id tobacco use contribute to the cause of death? ☐ Yes 2♥ No 3☐ Probably 4☐ Unknown		
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VITa	Physiclen: r this certific ral director, I	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	- A [[[] []]]	patient 3 □ DOA Oth	26. Place of Deat			7.1	
_	ffe ffe	on:To	27. Manner of Death 1 XNatural 5 Pending	28a. Date of Injur (Month, Day		Jalient 3 DOA	y at		ence 6 Other (Spec ow injury occurred	יייין (אוד)	
DIVISION	Attending or death. ector: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not l	28e. Place of Inju	ry - At home, farn	M 1 □ n, street, factory, office	Yes 2 □ No	28f. Location (Sa	reet and Number or Ru	ral Route Number,	
To the Hospital or Attendition within 24 hours after death,	urs after ral Dire		4 Hornicide	building, etc				City or Town			
	ne Hosp n 24 hol ne Fune pletely f	Medical			examination and	death occurred at the til or investigation, in my o					
	To the To the Committee of the Committee	Ž	29b. Signature and title of certifier	7.2	MD	29c. Licens	e number 53343	2	9d. Date signed (Month May 12,2		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)											
	Irina Ruban MD 1500 Forest Glen Road Silver Spring, Md 20910 State 31. Date filed (Month, Day, Year) 32. Alegistrar's Signature 31. Date filed (Month, Day, Year) 32. Alegistrar's Signature							: 0			
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amend item 8 per fh 8892 6-3-09 vt
State of Maryland / Department of Health and Mental Hygiene 2 0 0 9

1 - For State amend items 19a, 20a per fh g892 6 130-109 of Death

Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 7:40 AM Andersor /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner HOSPICE TIMORE year)940 9. Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Under Şex. 1 M 2 □ F 7. Age (In yrs. last birthday) **Funeral** 868 Months Days Hours Min. Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h. County Town or Location 28a-f show injury or other traumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No **Funeral Director** altimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with ō or items 23a 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Black 3altimore, Maryland 21215-0036 1 □Yes 2 No Specify. Specify: ģ permit. Pages I and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BUS ROW 38. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kru Anderson ပ္ Oliver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sister Ma 21207 twunn larice Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of pemetery, crematory or other p 1 😾 Burial 2 □ Cremation 3 □ Removal from State Daltimore. 4 ☐ Donation 5 ☐ Other (Specify) Greene Funeral Serv 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Kuto, Md Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mon Physician Aveinoin -V 50 /Medical Due to (or as a conse TWH Examiner Due to (or as a consequence of) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examir the attending physician and burial-trar Due to (or as a consequence of): 68760 Physician/Medical the as Box IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably ♠ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 1 No 2 NO 1 ☐ Yes Division of Vital 25. Was case referre o medical examiner? 26. Place of Death (Check only one) funeral director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 05 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner Death 28b. Time of 28c. Injury at ie Hospital or Attending P 24 hours after death. ie Funeral Director: After t After t 1 atural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Gamma Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 W. Xske Are, timer 31. Date filed (Month State 03 Registrar

eigy Anderson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 28 2009 3:10 A May Rosalie Austin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Co. Stella Maris Hospice Ctr. Timonium If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2CXF Yrs Director 72 13,1936 Maryland 219-32-9187 Aug. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 ☐ Yes 2 TX No ral", or items 23a or 28a-f sh Evaluar i puri be motified Director Dunda1k Maryland <u>Baltimore</u> 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 3329 Wallford Drive United States Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2X Married 2009 3:10 a.m. Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by 3 Widowed 4 Divorced "natural", White 16b. Kind of Business/Industry the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Federal than Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. 12 Years Administrative Assistant Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Grieb Irene Burns ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. Bruce W. Austin (Husband) 3329 Wallford Drive Dundalk, Maryland 21222 Baltimore, I 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite eny Injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery June 1, 2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222 21. Signature of ral Service Licens Wise Ave. Dundalk, Maryland 21222 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** a END STAGE RENAL DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Examir attending physician and for use as the burial-tran Due to (or as a consequence of): ROSALIE AUSTIN of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) signed by the a □Yes 2**X**No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by cate has been sign page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐Yes 2 **K** No 1 ☐ Yes 2 ☐ No Hospital or Attending Physicien: ours after death. eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: ${}_{4}\square$ Nursing Home ${}_{5}\square$ Residence ${}_{6}$ \square Other (Specify) \square HOSPICE 1 Yes 2 No Hospital: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 X Natural 5 ☐ Pending investigation 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only 2 Medical Examiner: On the basis of execution Nurse Practitioner er stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

24 hours a the 5

Registrar

31. Date filed (Mo State

29b. Signature and title of pertifie

JACKIE JONES, CRNP. 2300 DULANEY VALLEY RD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Ye ar Month **Physician** 19:15 ANDREWS 2009 MA 26 NO /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE N/A BAYVIEW MEDICAL CENTER FLOPKINS Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 260KF 78 213-28-1001 1930 West Virginia Sept. 25. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes XXNo Director Dunda1k Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9 21222 United States or items 23a 1734 Searles Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 ☐Yes 2 No If Yes, Give 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No þ 3 Widowed 4 Divorced White Year or Dates "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) than Elementary/Secondary (0-12) filed withir Hygiene. <u>Cosmetician</u> 11 Years <u>Avon Lady</u> Cosmetology s 1 and 2 should be filed of Health and Mental Hygi item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Veta Cross ပ Roy McClaughlin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 302 Upperlanding Road Baltimore, Maryland 21221 Mrs. Kandies Shearer (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1 Department of P Important: If ite any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5/29/2009 Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur / Ineral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death shock, or heart f dase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, are. List only one cause on each line. 23a. Part 1. Enter the Immediate Cause (Final **Physician** KESPIRATORY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-transit PSIS Exam Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown is certificate has been s director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No Hospital or Attending Physician: The I 24 hours after death.
 Funeral Director: After this certificate ha 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Man Jer of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated.

To the Hospital within 24 hor To the Fune completely fi

> h State

Registrar

1ZABE

2009

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

MD 4940 AVENUE BALTIMORE HARRIS 32. Registrar's Si

29c. License number

09-03735	
Louisa Alston	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

uisa Alston	1.	State of Maryland / Department of Health and M - For State Certificate of Death	ientai Hy		2. No.	009 1112
Physician		Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death
edical Examine		Low, 54 Alston 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Locat		May 9, 200	9 4c. County	1417 1115
	4	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Locat Bon Secours Hospital Baltimore	ation of Death		W)	
Funeral	Ę	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If I	Under 24Hrs.	8. Date of Birth		9. Birthplace (State or Foreign
Director	1	215-88-9760 1 M 2 Yrs. Months Days H	Hours Min.	Doclo,	1961	Country) Mary land
8	Į	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
ow an		MD MA Baltimore				1 Yes 2 No
Ba-f sh	5/	10e. Street and Number 10f. Zip Code		10	g. Citizen of W	hat Country?
the Man a or 2 ciffed	5	1814 Clifton Ave 2121	7		u	SA
15-0036 filed within 72 hours after death with the Maryland I Hygiene. I Hygiene and death with the Maryland de other than "matural", or items 23a or 28a-f site of other than "matural", or items 20a or 28a-f site of Cornarioted by Eumoral Director	<u> </u>	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic If Yes, specify Cuban, Mex	ic Origin? (Sp exican, Puerto	ecify Yes or No- Rican, etc.)		e - American Indian, Black, te, etc.
er deat		Never Married 2 Married 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specific Yes, Give Year	ecify:		Specify:	Black
urs aft tural" amine	3	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation ((Give kind of w			usiness/Industry
6 72 ho an "na cal Ex		Elementary/Secondary (0-12) College (1-4 or 5+)	NOT use retir	ea)	N	<i>1</i> <u> </u>
5-0036 iled within 7 Hygiene. I other than the Medica	Completed by	12 - 0 - Disabled 17. Father's Name (First, Middle, Last) 18.M	Nother's Name	(First, Middle, M		
21215-0036 Uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f show any e event, the Medical Examiner must be notified at once. To Be Commission			Nurie			
D 2121 should be fil and Mental I 7 is marked natic event,		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and				_
and 2 M	L	Murred Heard Mother 1814 Cliston A 20a. Method of Disposition (Name of cemeter		thrwe Date		21217 - City or Town, State
altimore, mit. Pages I ar partment of Her prortant: If ite	1	gromatory or other place)	* I	13 106	Coton	Am allow
[등 등 등 등 등	- 1	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of F	Facility	13,009	Carring	sville, rily
Balti permit. Departn Imports		Ronald a. Mayson Renald A.	1 Heter	- Pars	Ballo	.md 21229
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such failure. List only one cause on each line. Narcotic intoxication comp	h as cardiac o	r respiratory arre	est, snock, or n	Between Onset and
M_dical vaminer		Immediate Cause (Final disease a. myocardial fibrosis and chroni				Death
	П	b				
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause				
be ed		(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
		XUNPENDED d. AMENDED 23a,PII,27,28a-f,perME,	a892 6	717/09	тт	
e be exe	edical		g092 C		23d. Date	of delivery
tox 6876 eath certificate eathending phy for use as the b		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 E	Ectopic pregna	ancy	Month	Day Year
ath cer attendi	Physician/IV	4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 ✓ No 9 Unknown g Unknown				
	計	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	n in Part I.	23e. Did to	obacco use con	tribute to the cause of death?
P.C. sthat igned oe deta		Diabetes mellitus		1 Yes	3 2 No 3	Probably 4 V Unknown
of Vital Records, ig. Physician: The law requir ifter this certificate has been s neral director, page 2 should 1	Completed			24a. Was autop	sy	. Were autopsy findings available prior to completion of cause of
eco he law ate has	Ē			perfo 1 ✓ Yes	rmed? 2 No	death? 1 ✓ Yes 2 No
	ag Be	examiner?	Death (Check			
Sion of Vital Ratending Physician: reath. ector: After this certified by the funeral director.	0	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at		ng Home 5	Residence 6	
nding th. : Afte e fune	<u></u>	1 Natural 5 D (Month, Day, Year)		unk		
	<u>ā</u>	2 Accident 3 Suicide 6 X Could not be Pending Investigation Fd 5/9/09 unk 28e. Place of Injury - At home, farm, street, factory, office building Found at home.	ding, etc.	28f. Location (Street and Nun	nber or Rural Route Number, City
Div Hospital or 24 hours afte Funeral Di	Certification:	4 Homicide determined (Specify) Found at nome				Clifton Ave
		29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, de	and place, and	d due to the caus at the time, date	se(s) and mann and place, and	ner as stated. d due to the cause(s)
To the H within 24 To the F completel	Medical	29b. Signature and title of certifier 29c. License nu				gned (Month, Day, Year)
		0.C.M.E	E.		May 10, 2	2009
	+	30. Name and address of person who completed cause of death (Item 23a)				
-	35	Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltim	nore, MD 2	1201		
Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature				

3. Time of Death

Physic /Med Exam

Funera Directo

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. an "natural", or items 23a or 28a-f show Medical Examiner must be notified at

/Medica

Baltimore, Maryland 21215-0036 Physician Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunial-transit Division or Vital Records, P.O. Box 68760, State Registrar

ical	Benjamin Brudner				MAY	31,	2009	11:10 A M
iner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, о	r Location of Death		4	c. County of Deatl	1
	3511 Forest Edge Dr. #1G		Silver				Montgome	ery
	5. Social Security Number 112-01-8218	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da SEP 19	v. Ye	916 Solution 9. Birth Co. New	nplace (State or Foreign untry) York
	Usual Residence of Decedent 10a. State 10b. County 10c. City, 7	Town or Loc	cation					10d. Inside City Limits
5								1 □Yes 2X No
Director	Maryland Montgomery Sil	lver S	Spring			100 0	itizan of Mihat Co	unta (2
급			10f. Zip Code				itizen of What Co	
ra	511 Forest Edge Dr. #1G	140.0	20906		7 7		ited Stat	
Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Was Decedent of H f Yes, specify Cubi	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.))-	14. Race - Amer Black, White	
	1 □ Never Married 2 □ Married liXXX es 2 □ No if Yes, Give 9XXXVidowed 4 □ Divorced Year or Dates: WINT T	1	I∐Yes Ž ∭ZNo	Specify:			Specify: Whi	ite
Completed by	111	16a Deced	ient's Usual Occup	nation		16h	Kind of Business/l	nduetry
Set	(Specify only highest grade completed)	(Give I	kind of work done	during most of work d)	ing	100.1	Kind of business/i	Houstry
Ĕ	Elementary/Secondary (0-12) College (1-4or 5+)		es Manage			Mad	jor Appli	iances
Ö	17. Father's Name (First, Middle, Last)	Dar	es manage	18. Mother's Name	e (First, Middle			tances
To Be	David Brudner		,	Mary	Mas	sera	·	
1	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	a Address (Street	and Number or Run				(in Code)
	Mary I. Parker/Daughter			it Ct. Oal				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	20a. Method of Disposition 20b. Plac	ce of Dispos	sition (Name of		Date	20c. l	Location - City or	Town, State
	1 ☐ Burial ※XXCremation 3 ☐ Removal from State Ches 4 ☐ Donation 5 ☐ Other (Specify)	netery, crea sapeal	natory or other place ke y, Inc.	6/3/2	2000	Bo	eltsville	MT
	21. Signature of Funeral Service Licensee							; IID
	100 6 D- MOISS			ss of Facility eral & Cre				
-	23a. Part1. Enter the disease, or confincations that caused the death. shock, or heart failure. List only one cause on each line.	Do not ente	933 Gist erthe mode of dvir	Ave., Sil	ver Sp	ring	, MD	20910 Approximate
	immediate Cause (Final		or are mode or ayn	ig, occir ao caraido	or respiratory a			Interval Between Onset and Death
	disease or condition Pleural Effu							2 weeks
	Due to (or as a consequer							_
<u></u>	Sequentially list conditions, if any, leading to immediate b. Prostate Can Due to (or as a consequer							2 years
Ë	Cause (Disease or injury							
Examiner	that initiated events c. resulting in death) Last Due to (or as a consequer	nce of):		· - ·				
pgip	d							
ysician/Medical	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnanc						23d. Date of deli	verv
icia	in the past 12 months? 1 Ves 2 No 4 Pregnant at time of deat]Ectopic pregnancy] Other <i>(specify)</i>	4		İ	Month	Day Year
	9 ☐ Unknown							
by Pr	Part II. Other significant conditions contributing to death but not resulting	ing in the un	derlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
Q P					10	Yes	2√∏ No 3 ☐ Pr	obabiy 4 □Unknown
Completed					24a. Was	an	24b. Were au	topsy findings available
mc						ormed?	prior to death?	completion of cause of
Ö	25. Was case referred to medical			26. Place of Deatl	1 Yes	2 🙀 N	lo 1 □ Yes	2 □ No
OB	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER	3/Outnatien	t 3 DOA Oth	er.			6 ☐Other (Spec	nife)
	27. Manner of Death 28a. Date of Injury 28	8b. Time of			28d. Describe			ліу)
tion	1 ဩNatural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury		k? Yes 2 □ No				
fica	3 Suicide 6 Could not be determined 28e. Place of injury - At home	e, farm, stre	eet, factory, office		28f. Location (Street	and Number or Ru	ıral Route Number,
erti	4 ☐ Homicide determined building, etc. (Specify)				City or To	wn, Sta	te)	
al	29a. Certifier 1 Certifying Physician: To the best of my knowle	edge, death	occurred at the til	me, date and place,	and due to the	cause(s) and manner as	stated.
Medical Certification:	(Check only one) 2 ☐ Medical Examiner: On the basis of examination and manner stated.	n and/or inv	vestigation, in my o	opinion, death occur	red at the time	, date a	nd place, and due	to the cause(s)
ž	29b. Signature and title of certifier	, -	29c. Licens	e number		29d. D	ate signed (Monta	h, Day, Year)
	Daverd B. Herry	MI	D35	965		Jun	ie 1, 200	19
	30. Name and address of person who completed cause of death (tem 23)	3a) (Type, F	Print)		l.			
	David B. Harding, M.D. 18111 Pr	ince	Phillip	Dr. Suite	300 0	lney	, MD 208	332
ate	31. Date filed (Magth, Day, Year) 32. gistrac's Signatur							
trar	JUN (13 MILL) Strong	2 1	a si					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First Middle Last) Year **Physician** :05 SINGH 31 2009 104 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** GENERAL HOSPITA HOWARD COUNT COLUMBIA If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex **Funeral** Days 1 X M 2 □ F Months Hours Director Dec 19, 1948 India 176-66-1656 60 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County d 2 should be filed within 72 hours after death with the Maryfan Ith and Mental Hygiene. P? is marked other than "natural", or items 23a or 28a-f show traumatic event, It M. The Example of the confile 1 ☐ Yes 2√ No Director Columbia Maryland Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21044 11610 Sun Circle Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Marital Status 1 ∐Yes 2 TNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: <u>ک</u> 3 Widowed 4 Divorced Asian-Indian Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Department of General Services State of Elementary/Secondary (0-12) College (1-4or 5+) 5+ Mechanical Engineer Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Ikba1 Kaur Manohar Singh Babra ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 27 is any injury or other trau once. 11610 Sun Circle Way Columbia, Maryland 21044 Khushwant Babra/wife altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ACremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crematory 6/2/2009 Odenton, Maryland 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A. 21. Signature of Funeral Service Licer Thomas 1411 Annapolis Road Odenton, Maryland 21113 M00957 Approximate Interval Between Onset and Death 23a. Part the Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Congestive Car **Physician** week disease or condition resulting in death) /Medical a consequence of): Due to (or **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine signed by the attending physician and a betached for use as the burlal-transit The law requires that the death certificate be executed 5010vascuta 5050 Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 00 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes ➤ No 24a. Was an autopsy performed? Yes 2 No 1 □Yes I or Attending Physiclan: after death. 25. Was case referred to dedice examiner? 26. Place of Death (Check only one) Be 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signalure and title of certific 29c. License number 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NEWBERLY JORING 6946 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🚄 2. Date of Death Year J. BLASKIS Month Day June 2000 Jown, or Location of Death 4c. County of Death WERSIDE Year I If Under 24 Hrs 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1 □ M 2**X** F 93 10-14-1915 10b. County 10c. City, Town or Location HARFORD **EDGEWOOD** 10f. Zip Code 10g. Citizen of What Country?

1. Decedent's Name (First, Middle, Last) **Physician** CHRISTINE X OW /Medical 4a. Facility Name (If not institution, give street and number) Examiner 9. Birthplace (State or Foreign **Funeral** 212-18-5129 MARYLAND Director Usual Residence of Decedent 10a. State 10d. Inside City Limits 28a-f show ortant: If Item 27 Is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo MD Director 10e. Street and Number with 21040 U.S.A. 1940 HAREWOOD ROAD Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: WHITE XXWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 72 (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) DESIGNER FLORIST 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental ANTHONY SLECHTA JOSEPHINE (BLAZEK) ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is JEAN GUTOWSKI/DAUGHTER 1940 HAREWOOD ROAD EDGEWOOD, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 3 Removal from State -4 - 09DUNDALK, MARYLAND SACRED HEART JESUS 21. Signature of Funeral Servic Licen ee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME J. 21237 1211 CHESACO AVE ROSEDALE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) On /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine the death certificate be executed burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as IF FEMALE: use 23c. If ves. outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 Fetal death 3 Ectopic pregnancy Por in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 1 signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 9 1 ☐ Yes 2 No 3 Probably 4 dunknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page ; performed' certificate Division or Vital Physician: rector, 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Mayor of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending (Month, Day Year) Natural 5 ☐ Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No death To the Funeral Director: the 1 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide after To the Hospital within 24 hours at 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who complete ause of death (Item 23a) (Type, Print) 21001 31. Date filed (Month. Year Registrar's Signature Dav. Registrar

	1 - For State Registrar			d / Depa	artment of rtificate o	Health	and Me	ental Hy	giene Reg. No.	2009	1772
Physician /Medical	Decedent's Name (First, Middle	James	s.	Be	rtholdt,			2. Date of De Month May	31 ^{Day} 2	2009 ^{Year}	3. Time of Death 4:00 P M
Examiner Funeral	Gilchrist Cen 5. Social Security Number	ter	. Age (In yrs. k		4b. City, Town Tow If Under 1 Yea Months Day	son	24 Hrs. 8	(Month, Da	th	Baltimo: 9. Birthp	re Co. place (State or Foreign
Maryland f show led at tor	213-62-1412 Usual Residence of Decedent 10a. State 10b. County Maryland Bal	timore	54	Yrs. , Town or Lo	cation Dunda	112	M	larch 2	20,195		yland Od. Inside City Limits 1 □ Yes 2 No
fler death with the Mar ritems 23a or 28a-f s increast by retified Funeral Director	10e. Street and Number 69 Kinship Ro				10f. Zip Code)	222			in of What Cour	
E il., o	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decede Armed Force ied 1 ☐Yes 2 If Yes, Give Year or Date	es? ∰ No		Was Decedent o If Yes, specify Cu 1 □ Yes 2 XN			ify Yes or No can, etc.)		. Race - Americ Black, White, pecify: W	
ed within 72 hou ygiene. The Wedical Et. The Wedical Et.	Elementary/Secondary (0-12) 10 Years	t's Education st grade completed) College (1-4	or 5+)	(Give life. L	dent's Usual Occ kind of work dor DO NOT use reti ruck Dri	e during mos red) .ver					^{dustry} ng Industry
ould be file I Mental H narked oth natic event	17. Father's Name (First, Middle, Milton Bert	holdt				Na	ancy M	First, Middle,	5	·	
and 2 shalled and 2 shalled and 2 is m 27 is m her traum	19a. Informant's Name/Relations Roxanne D. Ber			434	ng Address (Stre	rs Ci	rcle	Belcan	np, Ma	aryland	21017
Dermit. Pages 1 Department of F mportant: If ite any injury or ot ance.	20a. Method of Disposition 1 ∰ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	pecify)	ne/ /	Lawn	sition (Name of natory or other p Cemeter	у 6,	Dat /3/200	19	Balt		Maryland
permi Depar Impor any ir	21. Signature of Foreral Service	11. ps	nly		Name and Add Duda-Ruc 7922 Wis	e Ave	. Dun	dalk,	Mary1		222
Physician /	23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on eac	sed the reath, h line.	S	er the mode of d	ying, such as	s cardiac or I	respiratory a	rrest,	4	Approximate Interval Between Onset and Death
executed and ial-transit Examiner	Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. HEF	ATTTT as a consequ	SC	VIRUS	INI	ECTI	ON			YEARS
eath certificate be executed attending physician and for use as the burial-transit cian/Medical Examir	resulting in death) Last	Due to (or	as a consequ	ence of):							
that the death certification bed by the attending place detached for use as the Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown		th 2 Tetal nt at time of de	death 3	Ectopic pregna Other (specify)				230	d. Date of delive	ery Day Year
equires that en signed I	Part II. Other significant condition			ting in the ur	nderlying cause (given in Part	l. 				he cause of death? Dably 4 🗌 Unknown
hysician: The law require his certificate has been sl I director, page 2 should be To Be Completed I	OF Was copy referred to medical						_	1 □ Yes	osy rmed? 2. No	24b. Were auto prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of 2 No
ng P	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin investig 2 Accident investig 3 Suicide 6 Could	28a. Date of (Month, pation not be 28a. Place of	Day, Year)	28b. Time of Injury	28c. In	other: 4 N jury at ork? Yes 2 N	ursing Home 28	d. Describe I	dence 6	g mil ann à mar diversità na ci	al Route Number,
ital or irs affe ral Dir illed in	4 Homicide determ	building	, etc. (Specify, est of my know	/ledge, death	n occurred at the	time, date a	nd place, ar	City or Tov	vn, State) cause(s) a	nd manner as s	stated.
To the Hosp within 24 hou To the Fune completely fi	29b. Signature and title of certifie	Examiner: On the basi and manner	stated.		29c. Lice	nse number			29d. Date s	signed (Month,	Day, Year)
0)	30. Name and address of person OAN IEUE DOBE 31. Date filed (Month, Day, Year)	who completed cause of	of death (Item	23a) (Type,	Print) OHARIG	5 ST.	5 8U 174	209	MAY	31, 20 7MIRE,	MD 21204
State Registrar	31. Date filed (Month, Day, Year)		istrar's Signatu	back)				<u> </u>		

		•	For State Registrar		,	Cer	tificate o	of D	eath			Reg. No	E 0 0 5	, ,	
		п	Decedent's Name (First, Middle, La	st)							2. Date of De Month	eath		3. Time of	
	Physicia Medic/		MESCAL E. BRAILER								May	29	2009	7:15	P M
	Examin	_	4a. Facility Name (If not institution, given	e street and number)			4b. City, Tow	n, or l	Location o	f Death		40	. County of Deat	th	
		•	LEVINDALE HEBREW GER	IATRIC			BA	ALTI	MORE						
\$	Funeral				e (In yrs. last bir	thday)	If Under 1 Ye	ear lys	If Under	24 Hrs. Min.	8. Date of Bi (Month, D	rth av. Year	9. Birt	hplace (State	or Foreign
	Director		217,56.2899	1□M 2√XF	77	Yrs.	WOTETS DO	.,,	Tiodio	141111	DEC 18,			OUNDLAND	, CANAD
	pu ,		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	orlo	cation							10d. Inside 0	Pity Limite
	aryla shov d at	<u>.</u>	Toa. State Tob. County		100. 01.91	101 20	odion								s & No
	he M 8a-f otifie	Director	MD ANNE ARU 10e. Street and Number	NDEL	(CLEN	BURNIE.	4.4				10a C	tizen of What Co		
	with t						10f. Zip Coo					rog. O		ountry:	
	s 23	Funeral	507 DELMAR AVE.	12. Was Decedent	Ever in II S	13 \		of His		ain? (Sn	ecify Yes or N	0-	USA 14. Race - Ame	rican Indian.	
	iter de	Ë	11. Marital Status 1 □ Never Married 2 Married	Armed Forces?			Was Decedent f Yes, specify (n, Mexican	, Puerto	Rican, etc.)	Ĭ	Black, Whit		
36	ırs af ıl", or xaml	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	I□Yes Ž	No	Specify:				Specify:	HITE	
2-0036	be filed within 72 hours after death with the Maryland ttal Hygiene. A other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ted	15. Decedent's E	ducation	16a.	Deced	dent's Usual Oc	ccupa	tion			16b. 1	Cind of Business	/Industry	
215	hin 7.	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5	5+)	life. L	kind of work do DO NOT use re	one au etired)	uring mos	t of work	ing				
2121	d wit giene grtha the	Ö	8				HOMEMAKE	ER					OWN HOME	,	
	al Hy l othe	Be (17. Father's Name (First, Middle, Las	t)					18. Mothe	r's Name	e (First, Middle	e, Maide	n Surname)		
Maryland	should be and Mental smarked o	2	THOMAS HARVEY						HAT	TIE P	EARL PAR	SONS			
an.	2 sho and is ma		19a. Informant's Name/Relationship		- 1								or Town, State,	Zip Code)	
	1 and 2 Health em 27		JANE SPILLNER	DAUGHTER			URNWOOD (21061			
altimore,	of of		20a. Method of Disposition 1 ☐ Burial 2X☐ Cremation 3 [Removal from State	20b. Place of cemeter	Dispo ry, crer	sition (Name o natory or other	t place	9)	ı	Date	20c. L	ocation - City or	Town, State	
Ē	Pages ment of tant: If its jury or o		4 □ Donation 5 □ Other (Spec	(fy)	BAYVIE	-						BALT	TIMORE, MD		
Ball	permit. Pag Department Important: I any Injury o		21. Sign William of Funeral Service Live	1			NAME ONE					ш	04004		
			K. CKEGORY		01148		26 CRAIN						21061	Approxima	ato
Ų,			23a. Part 1 Enter the disease, or conshock or heart failure. List on	one cause on each li	ne.	тот епт					or respiratory	arresi,		Interval B	etween
	Physician	1	Immediate Couse (Final disease or condition resulting in definition	_a. ACU	te ru	h	al +	91	lure	2				ZWK	(5
*	/Medical Examiner		resulting in deline	Due to (or as	a consequence	of):								2 W	110
		r.	Sequentially list conditions,	b. Due to lor as	a consequence	of/:								2 11	KS
d	ted nsit	nin	cause. Enter Underlying Cause (Disease or injury												
	al-tra	Examiner	that initiated events resulting in death) Last	C. Due to (or as	a consequence	of):									
68760,	icate be executed physician and s the burial-transit			► d											
89	rtificate ng phy as the	Medical													
X	leath cert attending	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		٥٦	75-4						23d. Date of de	livery	
P.O. Box	death e atte	Physician/	in the past 12 months?	4 ☐ Pregnant a	2 □ Fetal death t time of death		∐Ectopic pregn]Other <i>(specif</i>						Month	Day	Year
Ö	at the by th tache	hys	9 Unknown	9∐Unknown											
	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by F	Part II. Other significant conditions		1	9 1		- 4	4 1	21 -	.		use contribute t		
Records,	equir en si oufd l	ed	- Ciaiff C	olitis, 6	gastro	n r	ies finc	21	oje	cline	Y] Yes	2 X No 3□F	robably 4	Unknown
ec ec	has be ge 2 sh	ple									24a. Wa	s an opsy	prior to	utopsy finding completion of	s available cause of
	The ate h page	Completed									per 1∐ Yes	formed? 2 X N	death?	2.4	
Vita	I or Attending Physician: The I after death. Director: After this certificate ha I in by the funeral director, page	Be (25. Was case referred to medical examiner?							of Deat	h (Check only	one)			
7	hysia this c	2	1 ☐ Yes 2 No	Hospital: 1 Inpatie				Othe	4 🗆 NU	ursing Ho			6 □Other (Spe	ecify)	
Ē	ing F	on:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju		Time of Injury		Injury Work			28d. Describe	how inj	ury occurred		
<u>S</u>	ttend leath tor: /	cati	2 Accident investigation 3 Suicide 6 Could not !	20	At home for	rm etr			/es 2□	NO	70f Location	(Ctroot	and Number or F	Jural Poute Ni	mbor
Division or	or At	Certification:	4 ☐ Homicide determined	building, et	ury - At home, fa tc. <i>(Specify)</i>	um, su	eet, factory, or	iice			City or T	own, Sta	te)	iurai noute ivi	mider,
_	pitai ours a erai (Ce	29a. Certifier 1 CertifyIng F	hysician: To the best	of my knowledge	e, deat	h occurred at t	he tim	ne, date a	nd place	and due to th	e cause	(s) and manner a	ıs stated.	
,	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical		miner: On the basis of and manner st	of examination ar										e(s)
	Vithin or the complex	Me	29b. Signature and title of certifier	2			29c. Li	cense	number	7.0		29d. E	ate signed (Mor	th, Day, Year)	
	->-0)	regen.	1 12			DO	005	30	128	0	5/20	1/200	9
			30. Name and address of person who	completed cause of c	death (Item 23a)	(Type,	Print) (LI	R	AIYF	A B	ELZUA	1,1	ND		
			30. Name and address of person who	BELVEDE	ere A	VE	NUE	,	BAL	TIM	IORE	, M	D-21	215	
	Sta		31. Date filed (Month, Day, Year)	Z. negisti	rar's Signature	Ba	del								

09-04305 Kristen Chencus Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 17726

			- For State		· · · · · · · · · · · · · · · · · · ·	C	Certifica	ate of i	Death					Reg. N	0	- 1:		
	Physicia	_	Registrar 1. Decedent's Name										Date of I	Day	y Year		Time of Death0149 hrs	1
edina	l Exami		Krist		Ann		encus		o. City, Tow	n or lo	cation of I		May 30		4c. County o	f Death		
			4a. Facility Name (if 6603 Coppe			umber)		40	Baltimo		Callottori	Jean		ŀ	Baltimor		nty	
			5. Social Security N		Sex	7. Age (In y	rs. last birt	thday)	If Under	1 Year	If Under 2	24Hrs.	8. Date o	f Birth (M	M/DD/YYYY	9. Birth	place (State or	
	uneral irector	ì	001-64-9		M 2XF	34		Yrs.	Months	Days	Hours	Min.	May	13,	1975	Foreign Cou	ntry) NH	
		-	Usual Residence of														10d. Inside City	Limite
	any	Ī	10a. State	10b. County		10c.	City, Town										1 X Yes 2	
	Aaryland 28a-f show 1 at once	5	MD				Bal	timo						10a (Citizen of Wh	at Coun		
	Maryl 28a-l d at c	Director	10e. Street and Nur						10f. Zip C	∞e 1209				l log.	USA		.,	
) :	and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiera. Tis marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	Ö	6603 Cop	per Rid		ecedent Ever	in IIS	13 Was	Decedent	of Hispa	anic Origin	1? (Spe	cify Yes o	or No-	14. Race		can Indian, Blac	k,
,	ath wi	Funeral	11. Marital Status 1 X Never Marrie	ed 2 Marr	Annad	Forces?		If Ye	es, specify	Cuban, I	Mexican, F	Puerto F	Rican, etc.)	White	e, etc.		
\	her de ", or er mu		3 Widowed	4 Divor	ced If Yes, Give Y				Yes 2						Specify:		hite ————	
	ours al atural camin	d by	15. Decedent's Ed	lucation (Specif			ed) 16a.	Decedent	st of worki	ccupatio	n (Give ki	nd of wo	ork done ed)	16	b. Kind of Bu	isiness/It	ndustry	1
9	n 72 h an "n ical E	oleted	Elementary/Seco	ondary (0-12)	College 4	(1-4 or 5+)			acher						Educa	atio	n	
003	within giene. her th Med	ompi	17. Father's Name	(First Middle I				160	icher	18	3. Mother's	Name	(First, Mid	dle, Maio	den Surname			
21215-0036	al Hyged off	Be C	Joseph M										Gurcz					
212	Ment Mark mark	다 E	19a. Informant's Na				19								r, City or Tov		, Zip Code)	
MD	12 sho th and 127 is umati		Joseph M		us – Fat	ther			_			Han	npton Date		0384		Town, State	
<u>6</u>	s l and f Heal If iten		20a. Method of Dis		3 Removal		crema	atory or oth										1
e E	Page: nent o ant: or oth		4 Donation 5	Other Spe	ecify:		Metr		itan (Alexa		a, VA ral Hom	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygien Ameria Hiem II friem 27 is marked other than "natural", Important: If item 27 is marked other than "natural", Injury or other traumatic event, the Medical Examiner		21. Signat e of Fu	(_	icensee	γ_{α}		22. N	lame and A	Address (e Rd.		mpton,	
		1	23a. Par I. Enter t	he disease, or c	complications that	t caused the	death. Do	not enter t	he mode of	dying, s							Approximate Between Or	Interval
	nysician Medical		failure. List or	nly one cause o	on each line.												Deat	
	kaminer		Immediate Cause or condition result			s a conseque												
		Ę.	Sequentially list of		b. Due to (or a	s a conseque	ence of):									-		
		nine	if any, leading to in cause. Enter Und (Disease or injury	lerlying Cause	C.												<u> </u>	
	sd ssit	Examine	events resulting in		Due to (or a	s a conseque	ence of):											
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and To the Funeral Director. After this certificate has been signed by the attending physician and compleably filled in two the funeral director, nage 2 should be detached for use as the burial—transit	call	X UNPENDE		a	D 23a,	27,28	Ba-f,	perM	E , g	g892	6/1	2/09	TT				
.60,	te be e nysicia e buria	Medical	IF FEMALE:			es, outcome o		cv							23d. Date		-	
3876	rtifica ling pl	an/N	23b. Was deceden past 12 month		e 1 Liv	e birth		2 F	etal death		Ectopio	pregna	ancy		Month		Day	rear
Box 687	leath certific e attending for use as t	sician/	1 Yes 2	No 9 🗸 Unk		egnant at time iknown	e or death	5 O	ther (Spec	cify)								
	at the desired by the etached	H H	Part II. Other sign	nificant conditi		g to death bu	ut not resul	ting in the	underlying	cause g	iven in Pa	art I.					the cause of d	
9.	res thar signed be det	1 2															obably 4 U	
rd S	w requir is been s should	Completed	in T										24a	. Was ar autops	/	prior to	utopsy findings completion of c	available sause of
ဝ၁	te has	E E				-							1 🗸	perform Yes 2		death?		No
Ř	ysician: The l	ပို	25. Was case refe	erred to medical						26.Place	of Death	(Check	only one					
Vits	hysicis this ce I direc	To B	1 ✓ Yes	2 No	Hospital: 1	Inpatient		VOutpatier		OA .	Other4		ng Home		esidence 6		er: Scene	
o	ing Physical After this fineral dir	٦			(M	late of Injury lonth, Day,Year)	Bb. Time of	′ ′		ryatWorl Yes 2 ∑		sub	ject	was v	icti	im of	
ion	ttend death. ctor:	atic	2 X Accident	5 Pend	uianian 3/	30 / 200 Place of Injury		d 1:4			-				tal ho	-h F	Dougal Douga Nur	nber, City
Division of Vital Records, P.O	of after I Dire	Certification:	3 Suicide	deter	d not be 25e. If		siden		cot, idolory	,	- Lancer 19, -		Bal:	rown, Sta	ete) 6603 re, MI	СНс	pper Ri	Ldge D
5	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After t	ු පු		7	T. die	hank of more les	novelodao	death occ	urred at the	e time, d	ate and pl	ace, an	d due to t	he cause	(s) and man	ner as st	ated.	
	thin 24 the F	Medical	(Check only one) 2	/ Medical Exa	nysician: To the miner:On the ba and mann	isis of examin	nation and/	or investig	ation, in m	y opinior	n, death o	ccurred	at the tim	e, date a	nu piace, an	<u> </u>		,
	5 ± ₹ 5	Š	29b. Signature ar	nd title of certifie		ioi otatoo.			29		se number						nonth, Day,Year	7)
)		W	and.	ms.	1				O.C.	.M.E.				May 30,	ZUU9		
			30. Name and ad				th (Item 23	Ba)	eet, Balti	imore	MD 21	201						
			Ling Li, M		int Medical E	Registrar's	Cinnatura			inore,	1VID 2 1.	201				_		
	Door	State istra	e 31. Date filed (Mo	ontn, Day,Year)	2009	balling s	J.	ba	Kel									

amendation Marker Defarts 897 of Fleath att Mental Hygiene Certificate of Death Reg. No. 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Hmore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Year) Months Days 1 M 2 □ F 1648 Director Usual Residence of Decedent yes 1 and 2 should be filed within 72 hours after death with the Maryland of Heatth and Mental Hygiene. 10d. Inside Offy Limits 10c. City, Town or Location 10b. County 10a. State Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, the Medical Exprense must be notified at once. 1 ☑Yes 2 ☐ No Funeral Director altimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 □Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working Tife. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Father's Name (First, Middle, Last) Konert Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) 20c. Location - City or Town, State 20a. Methed of Disposition 1 ☑ Burial 2 ☐ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signatur uneral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 25か panlias Cancel **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if an leadin to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) attending physician for use as the burial Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) ed by the a P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Be Completed by 3 Probably 4 🗌 Unknown 2 🗌 No 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy perform 1 ☐ Yes 2 No **Division of Vital** the Hospital or Attending Physician: 25. Was case referred to medical examiner? within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address person who completed cause of eath (Item 23a) (Type, Print) (ean) 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

09-04282 Ced

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

dric M. Carter	1.	State of Maryland / Department of Certificate of Ce	of Health and Mental Hygiene of Death R	teg. No. 2009 17728
Physicia	R	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Dea Month May 29, 2	
Examir	er	Cedric M. Carter	May 29, 2 4b. City, Town, or Location of Death	4c. County of Death
	ľ	4a. Facility Name (if not institution, give street and number) St. Agnes Hospital	Baltimore	NIA
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	11 Chiasi - 1 Chi	irth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Worth Control
Director			rs. Months Days Hours Min. Juy	25, 140 country) D.CJ
	L-	Usual Residence of Decedent 10c. City, Town or Lo	cation	10d. Inside City Limits
w any	1	10a. State 10b. County 10c. City, 10wil of 20	Himore	1 Xes 2 No
daryland 28a-f show any d at once.	형	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
or 28s	Direc	2012 Barrigaton Ave.	21215	USA Plack
with the 11s 23a se noti	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Willie, Ctc.
death or iten must.l	Ine	1 Yes 2 No	Yes 2 No specify:	Specify: Black
hours after death with the Maryland "natural", or items 23a or 28a-f she Examiner must be notified at one	ā	3 Wildowed 4 Divolced or Dates:	dent's Usual Occupation (Give kind of work done	16b. Kind of Business/Industry
2 hour "nate	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	g most of working life. DO NOT use retired)	
5-0036 lled within 7 Hygiene. I other than the Medic	Completed	12 5	18.Mother's Name (First, Middle	e, Maiden Surname)
15-0036 filed within 72 I Hygiene. ed other than "		17. Father's Name (First, Middle, Last)	Ishelia D.	Grandison
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mohenl Hygiens I in Propriate: If item 71 is marked other than "natural", or items 23a or 28a-f shon injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	19a. Informant's Name/Relationship (Type, Print)	ailing Address (Street and Number or Rural Route N	Number, City or Town, State, Zip Code) Rato Ma 21215
and 2 should be lealth and Menta item 27 is marked traumatic even	_	Shelia D. Grandison-mother 38	23 Barrington AW, sposition (Name of cemetery, Date	20c. Location - City or Town, State
re, l s 1 and f Heals of item		20a. Method of Disposition Cremation 3 Removal from State crematory	or other place)	Raltimore, MD
Baltimore, permit. Pages I a Department of He Important: If ite		4 Donation 5 Other Specify: King	Jemorial tark 6607 22. Name and Address of Facility Howell	Funeral, Home
Balti permit. Departir Imports		21 Signature of Funeral Service Licenses	WAS Liberty Heights	s Ave, Balto MD 21267
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not en failure. List only one cause on each line.	iter the mode of dying, such as cardiac or respiratory	rarrest, shock, or heart Approximate Interval Between Onset and Death
Viedical aminer		Immediate Cause (Final disease a. Multiple Injuries		
tailine		or condition resulting in death) Due to (or as a consequence of):		
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Fo the within To the	comple	and mariner stated.	29c. License number	29d. Date signed (Month, Day, Year)
			O.C.M.E.	May 30, 2009
		30. Name and address of person who completed cause of death (Item 23a)		
1 V			111 Penn Street, Baltimore, MD 2120	01
	Sta	ate 31. Date filed (North Day 3ee 2009 22. Registrar's Signature	alla alla alla alla alla alla alla all	

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 7:06 P. M 30 Perry Cantrell 2009 May 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Anne Arundel Baltimore Washington medical Center Glen Burnie 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) Days Hours 1**X** M 2□ F 283 18 2934 02/27/1920 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County 1XYes 2 No N/A Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2523 Sidney Avenue U.S.A. 21230 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: ₩₩ II 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify. White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Palm Oil Recovery Welder 6th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Emmett Cantrell Nora Lee Hunt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Juanita Cantrell / Wife 2523 Sidney Avenue Baltimore, Maryland 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 A Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park: 06/05/2009 | Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 lenne framenus 23a. Part i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, but ck, or heart failure. List only one cause on each line. Immediate Cause (Final RETROPERITONEAL HEMATOMA disease or condition resulting in death) Sequentially list conditions, if any, leading to ininiediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CORONARY ARTERY DISEASE. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? MELLITUS RENAL PYSFUNCTION 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

/Medical Examiner ned by the a

Physician

/Medical

Examiner

Funeral

Director

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Physician

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Medical Certification: To

hours after death uneral Director;

CONGESTIVE HEART FAILURE. DIABETIS 25. Was case referred to medical examiner?

1 Yes 2 No 27. Manper of Death 1 ✓ Natural

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 29b. Signature and title of certifier

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

K. Do

29c. License number D0041284 29d. Date signed (Month, Day, Year) 30/09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAYMUNDO

300 Hospital Drive

Glen Burnie, Maryland

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 7,8 per fh g892 6-3-09 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 24, 2009 Month **Physician** 8:00 PM William /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death NIA 6809 Baltimore Street Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) North Carcling 8. Date of Birth (Month, Day, Aug, 1 5. Social Security Number 7. Age (In yrs. last birthday) 1928 **Funeral** Sex 1 M 2 □ F Hours Months Days 80 244-38-3025 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show 1 Yes 2 No Baltimore Director Maryland 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code Lyndhurst 21229 United States 825 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Examiner 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Bethlehem Steel Elementary/Secondary (0-12) College (1-4or 5+) Nachinist 10 27 Is marked other er traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Winfread Floyd John Cobb. 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 825 Lyndhurst Street Baltims re, Maryland 21239 19a. Informant's Name/Relationship (Type, Print) Elouise Cobbpermit. Pages 1 and Department of Health Important: If item 27 any Injury or other troonce. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State June 1 ■ Burial 2 □ Cremation 3 □ Removal from State OWM 45 Mills, Maryland Garrison Forest Veterars 2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Funeral Service, P.A. 270 Fredhilton Pass Baltimore Mary 21. Signature of Funeral Service Licensee, Fredhilton Pass Baltimore, Maryland 2109 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CARDIOMYOPATHY END **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Division or Vital Records, P.O. Box 68760, 7 The law requires that the death certificate be execut Due to (or as a consequence of) Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day 4□Pregnant at time of death 5 ☐ Other (specify) JYes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ hknown 1 ☐ Yes 2 □ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' To the Hospital or Attending Physician: ers after death.

eral Director: After this certific: filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Souther (Specify) RESIDENCE ۴ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Atural 28b. Time of 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and tipe 29c. License number 29d. Date signed (Month, Day, Year) M.D. D57722 28 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARDSON M.D. 1838 GREENE TREE ROAD #300 PIKESVILLE MD 21208 32. Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TEM#19a, per FH, G892, 6/8/09, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month A M Ellen M. Chandler 7:45 June 1. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Greater Baltimore Medical Center Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Dec 18, 19 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 □ M 2 💢 F Months Mary land Director 77 1931 <u>218-</u>28-3269 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🔣 No Director Md. Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1233 Wine Spring Lane 21204 USA Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home +4 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roland Ν. Ewell Marguerite Boulden ည or other traumatic 19a. Informantic Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Mary Chandler/ Husband 1233 Wine Spring Ln. Towson, Md. 21204 Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State injury Parkwood Cemetery 4 Donation 5 Other (Specify) 6-5-09 Baltimore, Md. 21. Signature of Funeral Service Licenseg 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Bal _1050 York Rd. Towson, Md. 21204 23a. Part 1. Enter the disease, it compiles floors that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Non Small **Physician** cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a sonsequence of): Hospital or Attending Physlcian: The law requires that the death certificate be executed signed by the attending physician and de detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 GUSHE Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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		_ For		Sta	te of	Marylan						lental Hy	gien/	е	h = 4"h	g 100-7 TH	700
	_	State Registrar					Ce	rtificate	e of L	Death			Reg. N	·20(19		133
Physicia	an	Decedent's Name	,	,		_						2. Date of De	D	009	Year	3. Time of 7:34	
/Medic	al		larenc				rucker	4b. City,	Four or	Leastion	of Dooth	May 28		c. County of	f Death	7:34	a • "
Examin	er	4a. Facility Name (If I						Beth	-		OI Death			Montgo		У	
Funeral		5. Social Security Nu		6. Sex		7. Age (In yrs.	last birthday)	If Under	1 Year	If Under		8. Date of Bi	rth		9. Birthp	place (State	or Foreign
Director		324-01-03	325	1 ½ M 2	□F	93	Yrs.	Months	Days	Hours	Min.	Oct. 3	0,	1915	III	inois	
pui w		Usual Residence of D	Decedent 10b. County			10c Cit	ty, Town or Lo	ncation							1	0d. Inside C	ity Limits
faryla	ō							Journal									2 X No
the N	Director	MD 10e, Street and Numl		omery		Bet	hesda	10f. Zip	Code				10g. C	itizen of Wh	nat Cour	ntry?	
3a or	Ö	4925 Bat		ane				208	14				Un:	ited S	Stat	es	
death	Funeral	11. Marital Status		12. Wa	s Deced	dent Ever in U	.S. 13.	Was Deced	ent of Hi	spanic O	rigin? (Spe	ecify Yes or N	0-		- Americ	can Indian,	
after or ite		1 Never Marrie		ried 1x]Yes :	2 □ No		1 □ Yes 2		Specify		, mount oton)		Specify:			
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withi	Completed	Elementary/Second	dary (0-12)	Co	llege (1- 2	4or 5+)	Purch	nasing	Man	ager	•		P	rinti	ng		
al Hyg othe vent,	Be C	17. Father's Name (F	irst, Middle,	Last)						18. Moth	ner's Name	(First, Middle	, Maide	en Surname)		
uld b Menta arked	70 E	Harry Dr	ucker							Ann	a Alt	erman					
2 sho and is ma		19a. Informant's Nar	me/Relations					•	,			al Route Numi					
and lealth m 27		Alison D		<u> </u>	dau	ghter)) Wils				nesda,		y Land Location - C			
iges 1 nt of H : If ite or of		20a. Method of Dispo 1 ☐ Burial 2 🛣	Cremation		l from S	itate i	Place of Disponentery, cre				May 3	30			-	Mary]	1 and
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exminer must be retified at once.		4 □ Donation 5				Cne	esapeal			- 1	2009	Funei					
Depa Impo any I			L			M0098	32	933 Gi	st A	lve.	Silve	er Spri	ing,	MD 2	0910)	. •
		23a. Part 1. Enter the shock, or heart	e disease, or	r complications	s that ca	used the deat	th. Do not en	ter the mod	e of dyin	g, such a	s cardiac	or respiratory	arrest,			Approxima Interval Be	etween
Physician		Immediate Cause (F	inal		sci											Onset and	Death
/Medical		resulting in death)		W		or as a conseq	uence of):										
Examiner	Ļ	Sequentially list cond	ditions,			static		ate Ca	nce	r					_		
ted nsit	Examiner	if any, leading to imm cause. Enter Underl Cause (Disease or in	nediate lying niury	₹	oue to (d	or as a conseq	quence or):										
cate be executed oblysician and the burial-transit	xar	that initiated events resulting in death) La		c	Oue to (d	or as a conseq	uence of):							.0			
te be ysicia	dical			d													
rtifica ng ph as th	/edi	JF FEMALE:															
eath certific attending p for use as	an/N	23b. Was decedent print the past 12 n				come of pregnation in the 2 - Feta		☐ Ectopic p	regnancy	y				23d. Date Mon		,	Year
at the dec by the a tached fo	Physician/Me	1 ☐ Yes 2 ☐ 9 ☐ Unknown			☐ Pregn ☐ Unkno	ant at time of	death 5	Other (sp	ecify)							,	
that the ed by detac		Part II. Other signific	cant conditi	ons contribution	ng to de	ath but not res	sulting in the u	ınderlying c	ause give	en in Part	1.	23e. Did	tobacco	o use contri	bute to t	the cause of	death?
uires n sign ld be	d by	Bone met	astas	is, Ren	nal	Insuff	icienc	у				1 🗆	Yes	2 ∑X No ∶	3□ Pro	bably 4 🗆	Unknown
w requires that s been signed t should be deta	Completed											24a. Wa		24b. W	/ere auto	opsy findings	s available
The la	шo											auto per 1 □ Yes	opsy formed? 2 🔯 N	de de	eath?	ompletion of 2 □ No	cause of
ian: irtifica stor, p	a	25. Was case referre	ed to medica	1	_					26. Plac	ce of Deat	n (Check only					
hysic his ce I direc	To B	examiner? 1 ☐ Yes 2 💹 N	No	Hospita	li: 1 🗆 Ir	npatient 2	ER/Outpatie	nt 3 DC	Othe	er: 4□N	Nursing Ho	me 5 🗆 Res	sidence	6 X ☐Othe	er (Speci	ify) Liv	isted ing
ing P	:uo	27. Manner of Death 1 Natural	5 Pendir	ng	n. Date o (Monti	of Injury h, <i>Day, Year)</i>	28b. Time of Injury		8c, Injur Work			28d, Describe	how in	jury occurre	ed		
ttend death stor: /	icati	2 ☐ Accident 3 ☐ Suicide	6 Could		Place	of Injury - At h	ome farm st	M reet factory		Yes 2		28f. Location	(Street	and Numbe	r or Rur	ral Route Nu	mber
lor A after Direc	Certification: To	4 Homicide	detern	nined 200	buildir	ng, etc. (Speci	ify)	roct, lactory	, onice			City or To			,, 0, 1,4,	ar rroute rvar	TIDOI,
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	edical C	(Check only	1 Certifying Medical	ng Physician Examiner: O	n the ba	asis of examina	owledge, dea ation and/or i	th occurred	at the tir	me, date a	and place, eath occur	and due to th	e cause e, date a	e(s) and ma	nner as	stated. to the cause	(s)
thin 2, the l	Med	one) 29b. Signature and t	Ae of certifie	Α	nd mann	er stated.		290	. Licens	e number			29d, [Date signed	(Month	, Day, Year)	
5 ≥ 5 8		b /		X	~	2			3557					5/2			
14.		30. Name and andre	ss of person	who complete	ed cause	e of death (Ite	m 23a) (Type	Dulmt								-	
17.1					~ (0 1 0 TT	4	- A++-	. Su	ite	305,	Bethes	da,	MD 20	U814		
Sta	te	Susan J 31. Date filed (Mont	UN Xear	2000	32.	egistrar's Sign	ature	F. no. 1	-								
Registr	ali not		00	4000	M		p. 19	arker			-						

DHMH 17 Rev 1/2001

09-04347 Will

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

William H. Evans		St - For State	ate of Maryla	ind / Depa	artment of	Health Death	and	Menta	al Hygiene	Dec No	20	ng i	773
Physicia	R	egistrar I. Decedent's Name (First, Midd	le.Last)		timouto or	Dodan			2. Date of D	Reg. No eath_	35-1-	3. Time of Death	
Medical Examir		William H. Eva							Month May 31,	2009	Year	1748 hrs	
		a. Facility Name (if not institution Johns Hopkins Bayvie	on, give street and nu		41	b. City, To Baltimo		ocation of	Death	4	c. County of Dea	ith	
Funeral		5. Social Security Number		7. Age (In yrs.	last birthday)	If Under		If Under		Birth(MN		Birthplace (State or	
Director		220 80 3358	1X M 2 F	40	Yrs.	Months	Days	Hours	Min. Dec.	10,1	968	Country) Maryla	and
		Usual Residence of Decedent										10d. Inside City I	imits
w any	- 1	Maryland Balt		10c. City	, Town or Location Balt							1 Yes 2 X	
rland -f sho	힐	Maryland Balt:	шоге		Balt.	10f. Zip (10g. C	itizen of What Co	ountry?	
e Mary	ğί	7418 Poplar Ave	nue				224				USA		
30 with the last 33 or notifice		11. Marital Status	12. Was Dec	cedent Ever in U	J.S. 13. Was	Deceden	t of Hisp	anic Origi	n? (Specify Yes or	No-		erican Indian, Black,	
7 + 303 r death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral	1 Never Married 2 X	farried Armed F	orces?					Puerto Rican, etc.)		Specify: Wh:		- 1
after	by F		vorced If Yes, Give Yea			Yes 2			ind of work done	116h	Specify: VIII.		
hours	E F	15. Decedent's Education (Spe Elementary/Secondary (0-12)		de completed) 1-4 or 5+)	during mo	ost of work	ing life. I	DO NOT	use retired)		wner/Ope		
136 hin 72 e. than edical	Completed	12	, comoge (,	Automo	tive	Tech	nici	an	A	utomotiv	e Repair	
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica		17. Father's Name (First, Middle			.1				Name (First, Midd	ie, Maide	en Surname)	•	1
121 I be fil ental I arked	m l	Benjamin Lawren			10h Mailine	Addross			es Brunn ber or Rural Route	Number	City or Town, St.	ate. Zip Code)	
MD 21 d 2 should lith and Me n 27 is man aumatic ev	-	19a. Informant's Name/Relation l'ina Marie Evar							Baltimo				
B, M and 2 Tealth trem 2	L	20a. Method of Disposition			. Place of Dispos	ition (Nam	e of cem	etery,	Date	20	c. Location - City	or Town, State	
MOFe, Pages an tent of He imt: If ite		1 Burial 2 X Crematic		rom State Ba	yview C	remat	ory	Inc.	5/2/2009	E	Baltimor	e, Maryla	nd _
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-5 sho injury or other traumatic event, the Medical Examiner must be notified at once.	ŀ	21. Signature of Funeral Service	e Licensee		22. N	lame and	Address	of Facility רוו לF	eral Home	2 P. /	Α.		
E P P E		234. Part I. Enter the disease, of	vrkouske		140	07 01	d Ea	ster	n Avenue	Ess	ex. Mary	land 2122	nterval
Physician // Medical		failure. List only one caus	e on each line.	caused the deal	in. Do not enter ti	ne mode o	oying,	3401140	and the property		,	Between Ons Death	
aminer		Immediate Cause (Final diseas or condition resulting in death)		a consequence	of):								
		Sequentially list conditions,	b. Pneumo					_					
	ine	if any, leading to immediate cause. Enter Underlying Caus	e	a consequence	of):								
, (/ p · š	Examiner	(Disease or injury that initiated events resulting in death) Last		a consequence	of):								
be executed ician and irial - transit	dical	X UNPENDED	dAMENDED	Pl liı	ne a-b,	PII,	2/ , p	erME,	, g893 7/	22/0	9 TT		
68760, certificate b rding physics se as the bur	울	IF FEMALE: 23b. Was decedent pregnant in	the	, outcome of pre		etal death	3	Ectonic	pregnancy		23d. Date of deli Month	ivery Day Ye	ar
x 68 h certif lending use as	ပေ	past 12 months?	4 Preg	nant at time of	de eth	ther (Spec	cify)		,				
Box re death c the atten	Physi	1 Yes 2 No 9 U	9	nown		undorly in a	001100.0	ivon in Pr	236	Did tobac	cco use contribut	e to the cause of dea	ath?
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Function: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	δ	Part II. Other significant cond History of r									2 No 3	Probably 4 V Uni	known
of Vital Records, Ig Physician: The law requir ther this certificate has been s neral director, page 2 should	ompleted	obesity (sta	tus post	gastric	by-pass	s), a	nd			Was an autopsy performe	prior	re autopsy findings a r to completion of ca th?	vailable use of
Rec The la	Com	Generalized	exfoliati	ng skin	rash					es 2	No 1 🗸	Yes 2	No
tal cian:	Be (25. Was case referred to medi examiner?	Hospital:	Innationt 2	ER/Outpatien		26.Place	of Death Other	(Check only one) Nursing Home	Re	sidence 6 C	Other:	
1 of Vi	То:	1 ✓ Yes 2 No 27. Manner of Death	28a. Dai	te of Injury	28b. Time of			ry at Worl			v injury occurred		
OD C ending ath. or: Af	tion		nding	nth, Day,Year)			1`	res 2	I				
Division tall or Attendir rs after death.	ertification:		vestigation 28e. Pla	ace of Injury - A	t home, farm, stre	eet, factory	, office t	uilding, e		ion (Stre wn, State		or Rural Route Numb	er, City
Di spital	Cert	4 Homicide	termined (Specif								-\ -nd manner as	estated	
Division Division To the Hospital or Attend within 24 hours after death wither Funeral Director: completely filled in by the	ical	29a. Certifier (Check only one) Certifying	Physician: To the b xaminer: On the basi	est of my knowl s of examination	edge, death occu n and/or investiga	urred at the ation, in m	e time, di y opinior	ate and pl i, death o	ace, and due to the ccurred at the time,	date and	d place, and due	to the cause(s)	
Tot Tot	Medical	29b. Signature and title of cert	and manner	r stated.				e number				(Month, Day, Year)	
		Dur	V,	M			O.C.	M.E.		,	June 1, 2009		
		30. Name and address of pers						5	ND 0400	4			
		Donna M. Vincenti,		Medical Ex	atura .	98	Street	, Baltim	ore, MD 2120	I			
S		31. Date filed (Month, Day, Yes	000 2.32.	Registrar's Sigr	Sark								

		State of Maryland / Department of H 1- State Registrar Certificate of L		ental Hygier Reg. N	2000	17735
		1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
Physi /Med	ician dical	ZELDA E. EVANS		MAY 31,		6:55 A M
Exam	niner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or GLENSHANNON CT. APT. N ESSEX	Location of Death		tc. County of Death BALTIMO	
Funera	_	5. Social Security Number 219-70-0600 6. Sex 1 M 25 F 7. Age (In yrs. last birthday) If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	8. Date of Birth (Month, Day, Yea MARCH 24	9. Birth Cou	place (State or Foreign ntry) MD
D	"	Usual Residence of Decedent		IIIKOII 24		
//arylai f show ed at	P	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits X☐ Yes 2☐ No
r 28a-	Director	MD BALTIMORE ESSEX 10e. Street and Number 10f. Zip Code		10g. (Citizen of What Cou	ntry?
th with use 23a o	ra D	6 GLENSHANNON CT. APT. N	21221		USA	
Z IZ IS-UU30 y within 72 hours after death with the Maryland yiene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	ispanic Origin? (Speci an, Mexican, Puerto R Specify:	oify Yes or No- lican, etc.)	14. Race - Ameri Black, White Specify: BI	
within 72 hours af ene. than "natural", or the Medical Exami	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	during most of working	g 16b.	Kind of Business/Ir	ndustry
7.0 7.0		12 ACCOUNTING CI			ALTIMORE	CITY
	Be C	17. Father's Name (First, Middle, Last) JOSEPH PARKER	18. Mother's Name (en Surname)	
Maryiand od 2 should be file lith and Mental H; 27 is marked oth	2	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street a			y or Town, State, Zi	p Code)
and 2 and 2 ealth an 27 is		BRANDI EVANS/DAUGHTER 2503 CHESHII				
DallIMOre, IMarylar permit. Pages 1 and 2 should be Department of Health and Menta important: If item 27 is marked any Injury or other traumatic er		20a. Method of Disposition 1 □ Burial 2 ▼ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY	6/2/0	9 BAI	Location - City or T	MD
Dennit. Depart import any inj	ouce	21. Signature of Funeral Service Licensee 22. Name and Address 1701 LA	SS OF Facility JAN URENS ST.,			ONS F.H., IN
		23a. Part1. Enter the disease, or complications that clused the death. Do not enter the mode of dyin shock, or heart failure. List only one cause on each line.		respiratory arrest,		Approximate Interval Between Onset and Death
Physiciai /Medica	_	Immediate Cause (Final disease or condition resulting in death) a. **Multiple** Auco resulting in death)	ma			18 months
Examine	_	Due to (or as a consequence of):				
P #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C				
cate be ex ohysician at the burial	dical E	d				
rtificate ng physias the	Medic	U				
w requires that the death certifichen signed by the attending should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ 9 ☐ Unknown			23d. Date of delive Month	very Day Year
quires that the signed by the detact	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Part I.			the cause of death?
2 2 70	Completed			24a. Was an autopsy performed 1 Yes 2 ☑	prior to condeath?	opsy findings available ompletion of cause of
Physician: T r this certificat	Be	25. Was case referred to medical examiner?	26. Place of Death			
Phys r this ral dir	2:	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othe 27. Manney Death 28a. Date of Injury 28b. Time of 28c. Injury	4 Li Nursing Hom	e 5 Residence 8d. Describe how in		ify)
r Attending ter death. irector: Afte	ation	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury Work	k? Yes 2 □ No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
al or Afte s after dez l Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28	Bf. Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 v.	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time of the desired physician in the property of the desired physician in the desired	ne, date and place, ar pinion, death occurre	nd due to the cause ed at the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier 29c. License		29d. I	Date signed (Month	, Day, Year)
		Sugran Rac, MD D57	770 3	6	11/09	
H		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suman Rab 9103 From Hin Square Dr. Bald 31. Date filed (Month, Day, Year) 32. Degistrar's Signature JUN 0 3 2009 Dune A. Spark	himore mi	2/237		
	State	31. Date filed (Month, Day, Year) 32. Degistrar's Signature				
Regis	straf	JUN 0 3 2009 Strove S. Jack				

09-04267 Glen Fernau Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

6

len Fernau	1. 6	State of Sta	of Maryland /	Departr	ment of icate of	Health a De <i>ath</i>	and N	Mental Hy		eg. No.	20	009 11	773
Physician/	Re	gistrar Decedent's Name (First, Middle,Last)		Cerun	cate or	Double			2. Date of Dea		Year	3. Time of Death 0045 hrs	
Priysician Nedical Examine	r	Glennon R.	Fern	a u				(D1	May 29, 2	2009	County of Deat		\dashv
(4a	. Facility Name (if not institution, give Sinai Hospital	street and number)		41	o. City, Town Baltimore		ation of Death		10.	County of Boar		
Funeral		Social Security Number 6. Security Number 93–84–8993	x 7. Age	(in yrs. last		If Under 1 \	_	Hours Min				ountry) MO	reign
Director		18.	M 2 F		Yrs.								
auk	_	oa. State 10b. County		10c. City, To								10d. Inside City Li	
8.	<u>.</u> 1	MO St. Lou	ıis		F1	orissa				10g. Citi	zen of What Co		-
th the Maryland 23a or 28a-f sho notified at once	10	De. Street and Number 1355 Pepper Hil	11				3033				USA		
or items	1	1. Marital Status Never Married 2 XMarried Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes If Yes, Give Year	985 [№]	1 1	es, specify Co	uban, M	lexican, Puerto specify:			White, etc.	White	
ours af		15. Decedent's Education (Specify or			6a. Deceden during m	t's Usual Occ ost of working	upation life. D	(Give kind of O NOT use re	work done tired)	16b.	Kind of Busines	s/Industry	ł
2 2 2 2	najaidillo 1	Elementary/Secondary (0-12) 12	College (1-4 or	5+)		ce Off	ic∈	er				forcement	
21215-0036 Build be filed within 7 Mental Hygiene. Barked other than c event, the Medica	7 ag	7. Father's Name (First, Middle, Last) George Fernau						Lois	ne (First, Middle Haged	om			
e, MD 21215-0036 I and 2 should be filed within Health and Mental Hygiene. Titem 27 is marked other tha	2 1	9a. Informant's Name/Relationship (T			19b. Mailing 1355	Address (Street a	and Number or	Rural Route N	ant,	Dity or Town, Sta	33	
<u>≒</u> ∞ ≒ = ≥	2	20a. Method of Disposition 1 X Burial 2 Cremation 3	XRemoval from Si	. cre	ematory or ot	sition (Name of her place) art Cer			Date /4/09		Location - City	ant, MO	
Baltimore, permit. Pages I ar Department of Hec Important: If the injury or other tr	2	Donation 5 Other Specify 1. Signature of Funeral Service 1 ic-	see Doro a	Marsh	all 22.	Name and Ad	dress c	of Facility Stove	ens Fun	eral	.Home I	nc · 21 230	
M 8 2 4 . s.		23a. Part I. Enter the disease, or com										Approximate In Between Onse	
Physician Medical	-	failure. List only one cause on e	ach line. Cardiac									Death	tunu
.aminer		Immediate Cause (Final disease a or condition resulting in death)	Due to (or as a cons left ven	oguence of)		portro	nhv	in acc	sociati	on w	ith		
		Sequentially list conditions, bif any, leading to immediate	Due to (or as a cons	sequence of)	gastr:	ic hem	orr	hage	, <u>,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</u>				
	.⊑∣	cause. Enter Underlying Cause (Disease or injury that initiated											
ted d ansit	EX	events resulting in death) Last	Due to (or as a con-							= 10	- 100		
0, e be executed sician and burial - transit	dical	X UNPENDED	AMENDED 23	a PI 1 as n	ine a	-b, PI er ME	I,2	7,perMI	E, g893	7/2	2/09 TT	iven	
Box 68760 to death certificate by the attending physical physical for use as the bunded	0) -	IF FEMALE: 3b. Was decedent pregnant in the	23c. If yes, outcome 1 Live birth	ome of pregn	ancy	etal death	3	Ectopic pres		ľ	23d. Date of del Month	Day Ye.	ar
Aecords, P.O. Box 6876. The law requires that the death certificate cate has been signed by the attending phypage 2 should be detached for use as the b	Physician/M	past 12 months? 1 Yes 2 No 9 Unknow		at time of dea		Other (Specif	y) _						
. Bo the dea	Phys	Part II. Other significant conditions		ath but not re	sulting in the	underlying c	ause gi	ven in Part I.	23e. D	id tobac		te to the cause of dea	
Records, P.O. I The law requires that the icate has been signed by the page 2 should be detache.	Ď	Obesity							- (Yes 2	22-22-22	Probably 4 V Unk	
rds, requir been s	Completed								l a	Vas an lutopsy lerformed	prio	re autopsy findings av r to completion of cau th?	use of
eco he law ate has	d mo								1 🗸 Y	es 2	No 1		No
tal Rection: The certificate ector, page	a)	25. Was case referred to medical examiner?	Monital:					of Death (Che	eck only one) ersing Home 5	Res	sidence 6	Other:	
of Vital ling Physician: Therefore this certif	P P	1 🗸 Yes 2 No	Hospital: 1 Inpa		ER/Outpatie 28b. Time o			y at Work?	-		injury occurred		
n of iding F h. Afte		27. Manner of Death 1 X Natural 5 Pending	(Month, Da	y,Year)	2021 1	,,		res 2 No					
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that th writin: 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach	Certification:	2 Accident Investig. 3 Suicide 6 Could n	1 28e Place of	injury - At h	ome, farm, st	reet, factory,	office b	uilding, etc.		ion (Stre wn, State		or Rural Route Numb	er, City
Divisi pital or Ati ours after d	Certi	4 Homicide determin	ned (Specify)						and due to the	coursels) and manner a	s stated.	
To the Hospital Within 24 hours To the Funeral Completely filled	edical	29a. Certifier (Check only one) Certifying Phys	ician: To the best of ner:On the basis of e	xamination a	ge, death oco nd/or investi	curred at the gation, in my	time, aa opinion	ate and place, i, death occurr	ed at the time,	date and	place, and due	to the cause(s)	
S distribution of the state of	Med	29b. Signature and title of certifier	and manner state	ed				e number		2	9d. Date signed	(Month, Day, Year)	
		ane 2					O.C.	M.E.			Иау 29, 200 ———	9	
1 ok seed		30. Name and address of person wh	no completed cause of tant Medical Ex	of death (Item	123a)	Street R	altimo	ore, MD 21	201				
1	ate		A	strar's Signa			Similif						
Panis		31. Date filed (Month Day, Year)	14 Alexan	v p.	MA CAL	Contract of the Contract of th							

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 3 Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 8:15 P M Мау 30 2009 Ferrandino Christine Jakobine /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert 156 Windcliff Road Prince Frederick If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 🕱 F 8/30/1934 150-40-5057 74 Germany Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours atter death with the Maryland ment of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show uny or other traumatic event, Item Medical Evans and the molified at 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2X No Director Prince Frederick MD Calvert 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20678 156 Windcliff Road Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 □ Never Married 2 □ Married 1 □Yes 2 No If Yes, Give Year or Dates: Specify: White Completed by 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Dept. of Defense 12 4 Management Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Berendina Buss Anton Loose 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7401 Bond Street, St.Leonard, MD 20685 Carolyn Johnson/ Friend 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/1/2009 Hanover, Maryland Anatomy Gifts Registry 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licens 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Bladder Physician years disease or condition resulting in death) /Medical Due to (or as consequence of): Sequentially list conditions, Due to (or as a consequence of): sician and burial-trans

Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. within 24 hours after death

To the Funeral Director:
completely filled in by the

Baltimore, Maryland 21215-0036

Cause Disease or injury that initiated events resulting in death) Last	c	uence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 🗆 Ectopic			23d. Date of delivery Month Day Year	
Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlying	cause given in Part I.	23e. Did tobacco u 1 □ Yes 25	se contribute to the cause of death? No 3 Probably 4 Unknown	
				24a. Was an autopsy performed? 1 □ Yes 2 \$\$\text{No}\$	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No	
25. Was case referred to medical	<u> </u>		26. Place of De	eath (Check only one)		
examiner? 1 ☐ Yes 2 📈 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 🗆 🗈	OCA Other: 4 Nursing	Home 5 Residence €	6 ☐ Other (Specify)	
27. Manner of Death ↑ Natural 5 □ Pending 2 □ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ∐Yes 2 ∏No	28d. Describe how injur	y occurred	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		ome, farm, street, facto	28f. Location (Street an City or Town, State	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier 1 Certifying Ph	nysician: To the best of my knownings: On the basis of examin	owledge, death occurre	d at the time, date and pla	ce, and due to the cause(s) and manner as stated. I place, and due to the cause(s)	

29c. License number

D0059061

Sulte 212

29d. Date signed (Month, Day, Year)

State Registrar

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM# 19a, per 1NF, G892, 6/17/09, WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1, Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 3:10 May 24, 2009 A^{M} Georges Smith Ε. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charles
 La Plata
 C

 If Under 1 Year
 If Under 24 Hrs.
 8. Date of Birth (Month, Day, Year)

 Months
 Days
 Hours
 Min.
 (Month, Day, Year)
 Charles County Nursing & Rehab Br County n Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛱 F Virgin Islands 66 May 11, Director 580-05-4293 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, The Medical Experiment must be retiffed at 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☑ Yes 2 ☐ No Director Prince George's Cheltenham 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20623 USA 10411 Angora Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Tyes 2 No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🖾 No If Yes. Give Specify. à 3 Widowed 4 Divorced Black Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Day Care 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mavis Brathwaite Ernest Smith ဂ 19a. Informant's Name/Relationship (Type. Print).

Mavis S. Georges (Daughter)

Mavis Georges (Mother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10411 Angora Drive Cheltenham, MD 20623 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Charlotte Amalie 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Western Cemetery 6/2/09 St. Thomas US VI 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service icensee 22. Name and Address of Facility Turnbulls Funeral Home 3815 Crown Bay #10 St. Thomas US VI 00802 puny 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Hepalic Encephalopathy
onsequence of):
Hepalatitis B Immediate Cause (Final disease or condition resulting in death) day S. Physician /Medical Due to (or as a consequence of): month & Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Day to for seigleoneschenes of Examiner death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □Yes 2 ☒ No 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ , Anaemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed failuse 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No 1 □Yes 2X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4

Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ∐Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA ۵ this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred After t 28c. Injury at Work? Certification: 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one)

Division of Vital Records, o the Hospital or Attending Plantin 24 hours after death.
o the Funeral Director; After the ompletely filled in by the funeral 0

> State Registrar

29b. Signature and title of certifier

Ravinder Sindhwani, MD 6 Post Office Rd., Waldorf, Maryland 32. Registrar's Signature 31. Date filed (Month, Day, Year) JUN 0 3 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated R. Sindheur

29c. License number

20061614

29d. Date signed (Month, Day, Year)

5/28/09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ 101	Department of Health and N	lental Hygier	ne
			1 - State Registrar	Certificate of Death	Reg. I	10.2009 17739
	Physici	an	1. Decedent's Name (First, Middle, Last)			3. Time of Death
	/Media	cal	FLORENCE W. GARDNER 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		, 2009 10:10 A ^M .
	Examir	ıer				
	Funeral		OAKCREST CARE CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last bi	PARKVTLLE irthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	BALTIMORE 9. Birthplace (State or Foreign Country)
5	Director		217-03-0238 1 M 2 X F 93 Usual'Residence of Decedent	Yrs. Months Days Hours Min.	8/7/1915	MARYLAND
	w w		Usual 'Residence of Decedent 10a. State 10b. County 10c. City, Tow	vn or Location		10d. Inside City Limits
	Maryk f sho	ō	MD BALTIMORE	PARKVILLE		1 □ Yes 2 → No
	r 28a	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	death with the Maryland ms 23a or 28a-f show rmust be rollifed at		8820 WALTHER BLVD. APT. 2518	21234		USA
5	ems er m	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
39	s afte	by Ft	1 □ Never Married 2 □ Married 1 □ Yes 2 □ Xio	1 ☐ Yes 2 ☐ No Specify:		Specify: WHITE
21215-0036	hour ttural	ed b	3 🛱 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a	a. Decedent's Usual Occupation	16b.	Kind of Business/Industry
215	e. In "na Medic	plet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)	ina i	BALTIMORE COUNTY
	d with	Completed	6+ YEARS	GUIDANCE COUNSELOR		SCHOOL SYSTEM
Maryland	be file tal Hy d oth event	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	en Surname)
\ <u>\</u>	d Men narke	은	EDWARD WARRINGTON		WHITAKER	T O
ĭa Na	d2st than than traur			b. Mailing Address (Street and Number or Rui		•
	f Heal tem 2		20a. Method of Disposition 20b. Place of	1112 OAK RIDGE COURT of Disposition (Name of ery, crematory or other place)	BEL AIR, Date 20c.	MD 21014 Location - City or Town, State
S E	Pages ent o nt: If i		I Burial 2 Cremation 3 Hemoval non State		/2009 CA	ATONSVILLE, MD
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ine Medical Examiner must be notified at once.		21. Signature of Euneral Service Licensee MOO217	22. Name and Address of Facility THE		
<u> </u>	89 5 8 8) (A	8521 LOCH RAVEN BL	VD. TOWSO	ON, MD 21286
3			23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician			ge dementia		0,,001 and 2 dam
	/Medical Examiner		Due to (or as a consequence	6():		
*		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter U derly, g Cause (Disease or injury	of):		
6	executed n and al-transit	Examiner	that initiated events			
٥,	e exe sian ar urial-t	Exi	resulting in death) Last Due to (or as a consequence	of):		
8760	icate be executed physician and the burial-transit	dical	d			
9	certifii ding p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			Old Date of delivery
Вох	atten for us	sician/Me	in the past 12 months?	h 3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
P.O.	the d by the	Physi	1 Yes 2 Solo 4 Fregulat at time of death 9 Unknown	o Z o tho: (openin)		
	w requires that the death certifi been signed by the attending should be detached for use as	by PI	Part II. Other significant conditions contributing to death but not resulting		23e. Did tobacc	to use contribute to the cause of death?
ğ	equire en siç ould b	edk	myelodipplastic x	undrome	1 ☐ Yes	2 No 3 Probably 4 Unknown
ec ec	2 2 2	Completed		*	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
<u>~</u>	ician: The lav certificate has rector, page 2:	Ş			performed	
Vita	ician certifi ector,	Be	25. Was case referred to medical examiner? Hospital: Hospital:	Tau 1	th (Check only one)	
of	ding Phys n. After this of	-To	1 Tes 2 ER/C	outpatient 3 DOA 48 Nursing Ho	ome 5 Residence	6 ☐ Other (Specify)
Division of Vital Records,	nding th. : Afte e fune	Certification:		Time of Injury at Work? M 28c. Injury at Work? 1 □ Yes 2 □ No	Edd. Boodings now ii	,u., , 0000
visi	Atter or dea ector by the	ifica	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, f building, etc. (Specify)	arm, street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number,
Ö	tal or s afte al Dir ed in	Cert	a Tromicide Building, etc. (Specify)		City of Town, St	ate/
	Hospi 4 hour Funer tely fill		29a. Certifier (Check only (C			
12	To the Hospital or Attending Physician: The law requires that the death certifiwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	one) and manner stated. 29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
	7 × 5 8	_		UD 806734	_	
	}		30. Name and address of person who completed cause of death (Item 23a)	The second secon	2 (6-1-2009
			Alice M. BRAZICA 8832 WE		le. MD 21	234
	Sta		31. Date filed (Month, Day, Year)			
	Registr	ar	IIIM o o oooo /2	had I		

DHMH 17 Rev 1/2001

6/1/2009

Hardner, Florence

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Ma	iryianu		tificate of		u Mentai i	Tygler Reg. N		1771.0	
	Physici		1. Decedent's Name (First, Middle,	Last)					2. Date of		Day Year	3. Time of Death	
	Physici /Medic		Doreen Marie						May	31	2009	4:43 P M	
	Examin	er	4a. Facility Name (If not institution, g					4b. City, Town, or Location of Death			4c. County of Death		
			203 Howard Stree 5. Social Security Number 6		(In ure la	st birthday)	Elkton If Under 1 Year	If Under 24	Hrs. 8. Date o	Rinth	Cecil	thplace (State or Foreign	
	Funeral Director		163-28-8263	1 M 2 M F	87	Yrs.	Months Days		Ain. (Month	, Day, Yea /1921	ar) Co	aland	
	pui »		Usual Residence of Decedent 10a. State 10b. County			Town or Lo	cation		10/2/			10d. Inside City Limits	
	h the Marylan r 28a-f show r notified at	or	MD Cecil	9	Elk		Sation					1 ☑ Yes 2 ☐ No	
	r 28a-	Director	10e. Street and Number		EIK	COH	10f. Zip Code			10g. (Citizen of What Co	ountry?	
	th wit	al D	203 Howard St	ceet			21921			1	U.S.A.		
	r dea lems er mi	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. V	Vas Decedent of H	lispanic Origin' an, Mexican, P	? (Specify Yes o uerto Rican, etc.	No-	14. Race - Ame Black, Whit		
36	y within 72 hours after death with the Maryland piene. r than "natural", or items 23a or 28a-f show the Me Xeal Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	0		□Yes 21X No	Specify:			Specify: Wh		
215-0036	2 hour		15. Decedent's	Education	J.	16a. Deced	ent's Usual Occup	ation		16b.	Kind of Business		
Z	within 72 liene. than "nat	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5-	+)	(Give l life. E	kind of work done of NOT use retired	during most of d)	working				
A	e filed w Il Hygier other th		12. Father's Name (First, Middle, La	net)		Specia	1 Educat				ducation		
and	be d d	Be c	Bartholemew Call	•					Name <i>(First, Mic</i> Roberts	iuie, iviaiui	en Surname)		
\leq	2 should and Mer is marke raumatic	은	19a. Informant's Name/Relationship		I	19b. Mailin	g Address (Street			ımber, City	y or Town, State, .	Zip Code)	
_	nd 2 ulth a 27 is r tra		Michael Graff/ S	Son		203	Howard S	treet.	Elkton.	MD :	21921		
ore	ges 1 au it of Hea if Item or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	□ Removal from State	20b. Pla	ce of Dispos	sition (Name of natory or other place		Date		Location - City or	Town, State	
Баппто	t. Pages tment of I tant: If It		4☑Donation 5 ☐ Other (Spe	cify)	Anato		ts Registry		2/2009		nover, M		
g	permit. Pages Department of Important: If II any injury or once.		21. Signature of Funeral Service Lie	ensee			Name and Addre						
	# x		23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that caused ly one cause on each lin-	the death.	Do not ente	er the mode of dyir	ng, such as car	diac or respirato	ry arrest,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a. Part	Sin	50.	15	Dis	eas	-e		Onset and Death	
	/Medical Examiner		resulting in doubly	Due to (or as a	conseque	nce of):							
	1000	Jer	Sequentially list conditions, if any, leading to immediate cause. Lines Underlying Cause (Disease or injury										
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	siclan: The law requires that the death cer certificate has been signed by the attendin rector, page 2 should be detached for use.	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown			Other (specify)			_	Month	Day Year	
ŗ	that the ed by detacl		Part II. Other significant condition	contributing to death bu	t not result	ing in the un	derlying cause giv	en in Part I.	23e, [oid tobacco	o use contribute to	o the cause of death?	
cords	quires in sign uld be	d by							_ 1	□Yes	2 X No 3□P	robably 4 □Unknown	
מנו	law re as bee 2 sho	Completed								24a. Was an 24b. Were autopsy findin			
	t The	Com								utopsy enformed? es 2	? death?	completion of cause of	
N I I	certifi	Be	25. Was case referred to medical examiner?	Hospital:			Oth		Death Check or				
5	Phys rr this eral dii	은	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpatier		R/Outpatient 8b. Time of	28c Injur	4 L Nursir			6 □Other (Spe	ecify)	
5	ath. r: Afte	atior	1 Natural 5 □ Pending 2 □ Accident investigat	(Month, Day	Year)	Injury	28c. Injur Worl	k? Yes 2⊡No			, , , , , , , , , , , , , , , , , , , ,		
2	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		y - At hom (Specify)	e, farm, stre	eet, factory, office			n (Street Town, Sta		ural Route Number,	
3	spital ours at leveral C		29a. Certifier 1 Certifying	Physician: To the best o	f my knowl	edge death	occurred at the tir	me date and n	lace, and due to	the cause	o(s) and manner a	e etated	
	n 24 h	Medical	(Check only 2 Medical Ex	aminer: On the basis of and manner state	examinatio	n and/or inv	estigation, in my o	ppinion, death	occurred at the ti	me, date a	and place, and du	e to the cause(s)	
	To th To th	ž	29b. Signature and title of certifier			1/	29c. Licens	e number		29d. [Date signed (Mon	th, Day, Year)	
1				2 -			7)005	3644	19	6/1/	09	
	l V		30. Name and address of person wh		ath (Item 2	3a) (Type, F	rint)	15.	to 20	2 F	=1XI	WD21921	
70	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signatu	re t	ngno	- Jul	1-00		INTON	V-DALJAJ	
	Registra	ar	MIN o a sone	1	6	1. 1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. / 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month 5 PM N009 COMI 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) **Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year)

July 3,1938 If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 5. Social Security Number Age (In yrs. last birthday, 1 🕱 M 2 🗆 F 70 Maryland 219-26-7611 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County 1 Yes 2 No Dunda1k Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 1919 Dineen Drive 21222 United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 ☐
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify Specify: 3 ₩ Widowed 4 Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done d life. DO NOT use retired) during most of working Mars Supermarkets Elementary/Secondary (0-12) College (1-4 or 5+) Trucking Industry 10 Years Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Violia Krumbine William Hoxter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2304 Putty Hill Ave. Baltimore, Maryland 21234 Mr. Louis Hoxter (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 1 Removal from State Oal Lawn Cemetery 6/3/2009 Baltimore, Maryland 4 Donation Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Tothalia resulting in death) Due to (or as a consequence of)

Physician /Medical Examiner

Physician /Medical

Examiner

10a. State

Director

Funeral

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Funeral

Director

28a-f show must be notified at

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items 23a

th and Mental Hygiene. ?7 is marked other than "natural", or iter traumatic event, the Medical Examiner

Health a

Department of Health Important; If item 27 any injury or other tronce.

with the Maryland

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Director; After this d in by the funeral

Division of Vital Records, P.O. Box 68760,

Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consec			A++	×3	
edical		d					
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of o	al death 3 🗌 Ectopi	c pregnancy (specify)		23d. Date of delive Month	ery Day Year
Ş	Part II. Other significant conditions of	ontributing to death but not re	sulting in the underlyin	ng cause given in Part I.	23e. Did tobac 1 □ Yes	co use contribute to the	
Completed			•		24a. Was an autopsy performed	prior to co death?	psy findings available mpletion of cause of 2 No
Be	25. Was case referred to medical			· 26. Place of De	ath (Check only one)		
10 B	examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 - Nursing	Home 5 🗆 Residence	e 6 🗆 Other (Specif)	<i>(</i>)
	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how	injury occurred	
Certification:	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of injury - At h building, etc. (Speci	ome, farm, street, fact	ory, office	28f. Location (Stree City or Town, S	et and Number or Run tate)	al Route Number,
Medical C	29a. Certifier 1 Certifying Ph (check only one) 2 Medical Exar	nysician: To the best of my knowniner: On the basis of examinand manner stated.	owledge, death occurr ation and/or investigat	ed at the time, date and plac- ion, in my opinion, death oc	ce, and due to the caus curred at the time, date	se(s) and manner as se and place, and due	stated. to the cause(s)
Me	29b. Signature and title of certifier)			29c. License number	29d.	. Date signed (Month,	Day, Year)

O00

600 North Wolfe St, Baltimore, MD, 21287

Registrar DHMH 17 Rev 1/2001

State

within 24 hours a To the Funeral D

6+1

31. Date filed (Month, Day, Year)

JUN 0 3 2009

Jacks

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 30, Day 2009 Year **Physician** Rosebud Jones 9:30 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heartland Healthcare Adelphi Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea. 1/10/1911 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 051-12-3563 1 M 2 K 98 **Director** SC Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, if a Medical Experimental be notified at 10a. State NJ Essex Newark 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ä 07106 13 Crescent Court USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after dea. Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "" any Injury or other traum". 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married **Black** 1 ∐Yes 2**K** No Specify Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Receptionist Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marshall Jones **Emma** Simmons ပ 19a. Informant's Name/Relationship (Type. Print)
Rosebud Jones / Niece 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 Crescent Court, Newark, NJ 07106 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fairmount Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 6/4/2009 Newark, NJ 4 ☐ Donation 5 ☐ Other (Specify) Porota Marshall 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. Down wwska 1501 E. Fort Avenue, Baltimore, MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final hovoscleritie Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last iner Dire to for as a nonsequence or, requires that the death certificate be executed attending physician and for use as the burial-transi Exami Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Day Year 5 Other (specify) Ö s been signed by the should be detached 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has tirector, page 2 si autopsy performed' 1 □ Yes 2 No 2 DA To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner Jath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Hatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) II DUO 60100 06-01-19 DOO 60/00 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 51 Silverspap University BLVD 2mil 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2009 mAY <u> 1990e</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Social Security Number Age (In yrs. last birthday) **Funeral** 1 **X** M 2 □ F 30, Virginia June 84 **Director** 225-26-6545 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f shov "natural", or items 23a or 28a-f sho dical Examiner must be notifled at 1 X Yes 2 ☐ No Director Laurel MD Prince George 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20707 1120 Beall Place Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after ealth and Mental Hygiene. 2 🗌 No 1 ☐ Never Married 2 X Married XYes Specify: White If Yes, Give Year or Dates: 1943-46 1 ☐ Yes 2 X No Specify. ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) National Security College (1-4 or 5+) Elementary/Secondary (0-12) is marked other than Agency Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eula Florence Stevens မ Reece Ray Jones traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1120 Beall Place, Laurel, Maryland 20707 item 27 i /spouse Edith P. Jones other 1 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pages
Department of
Important: If it
any injury or o Dorsey, Maryland June 5, 09 Meadowridge Mem. Pk.; 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licens of Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. M00773 Approximate Interval Between Onset and Death Immediate Cause Fin I disease or condition Due to (or as a consequence of): month Physician resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of: g physician and as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month in the past 12 months? Pregnant at time of death 5 Other (specify) signed by the at 2 No 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2/No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 2 🗌 No 1 🗌 Yes 2 No Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Hospital: 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 ☐ Yes 2 ☐ No

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attending after death. Director: Aft the 1 filled in by 24 hours Hospital

with

Baltimore, Maryland 21215-0036

Certification: Medical within 24 hou

To the Funer

completely fil

5 Pending investigation 2 Accident

Could not be determined 3 Suicide 4 - Homicide

29a. Certifier

(check only one)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29b. Signature and title of certi-

29c. License number RES-000 29d. Date signed (Month, Day, Year) 29, 2009

30. Na. / and address of person who comple d cause of death (Item 23a) (Type, Print)

and manner stated.

ASON [UROWSKI MD 31. Date filed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

State Registrar



DHMH 17 HeV 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Of Marylan State Registrar	-	artment of Hea rtificate of De			eg. No. ? / / / (2 1771.1.		
	Dhusisi		1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month		3. Time of Death 3:/2 p. M		
	Physicia /Medic			iane	Jones	- dies of Death	05	29 Og 4c. County of De	,		
	Examin	er	4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital		4b. City, Town, or Loc Baltimo			N/A	aut		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.		If Under 1 Year If		8. Date of Birth (Month, Day,	Year) 9. B	rthplace (State or Foreign Country)		
	Director		217-68-3909	Yrs.			April 3	3, 1964 M	aryland		
	yland how		10a. State 10b. County 10c. Cit	y, Town or Lo					10d. Inside City Limits		
	Ra-fs	Director	Maryland N/A			more Cit		0g. Citizen of What C	1) Yes 2 No		
	with t		10e. Street and Number		10f. Zip Code 2120	16	'	United S			
	death	Funeral	4410 St. Thomas Ave. 11. Marital Status 12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of Hispa If Yes, specify Cuban, N		cify Yes or No-	14. Race - An Black, Wh	nerican Indian,		
36	s after ", or its	y Fu	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:			Specify:	,	Specify:	Black		
9-0	be filed within 72 hours after death with the Maryland tial Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medeal Evan her must be netitied at	Completed by	15. Decedent's Education	16a. Dece	dent's Usual Occupation	n		16b. Kind of Busines			
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lan	should be fand Mental s marked o	To Be	Walter Jones, Jr.			C	Cleo Gil	lespie			
/ar	2 short and the list ma		19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street and Number or Rural Route No. 7734 Dory Lane Edgemere,				mber, City or Town, State, Zip Code) Maryland 21219			
.e, 1	ges 1 and 2 should nt of Health and Mer If item 27 is marke or other traumatic		Mrs. Cleo Jones (Mother) 20a. Method of Disposition 20b. F		osition (Name of matory or other place)			20c. Location - City of			
E O	Pages nent of int: If ii				service Co	rp. 6/2/	2009	Towson,	Maryland		
Baltimore, Maryland 21215-0036	permit. Pages 1 am Department of Heal Important: If item 2 any injury or other once.		21. Sign tur Funeral Service Lic See	22 I	2. Name and Address o Duda-Ruck F 1922 Wise A	f Facility uneral I	Home of	Dundalk,	Inc. 21222		
r			23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	h. Do not ent	ter the mode of dying, s	such as cardiac o	r respiratory arr	rest,	Approximate Interval Between Onset and Death		
Sag.	Physician		Immediate Cause (Final disease or condition resulting in death)								
7	/Medical Examiner		Due to (or as a consequence of the consequence of t								
	7 ±	ner	Sequentially list conditions, if any, leading to immediate cause. Evan Understanding Due to (or as a consequence of):								
18.	xecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. END STAGE LIVER DISEASE Due to (or as a consequence of):								
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	ertificat ing phy e as th		IF FEMALE:	-							
Вох	death cert ie attending id for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnation in the past 12 months? 4 □ Pregnant at time of	l death 3	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of o	delivery Day Year		
P.O.	0 0	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	30411 01							
Division of Vital Records, F	law requires that the de as been signed by the 2 should be detached	þ	Tarris, Other digital contained to the library to death but not receiving in the analyting states grown at the						id tobacco use contribute to the cause of death? ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown		
ooa	12 13 B	Completed					24a. Was a		autopsy findings available to completion of cause of		
E B	lcian: The lav certificate has ector, page 2:	Com					performed? death? 1 🗗 Yes 2 🗆 No 1 🗀 Yes 2 🗀 No				
Vit	ding Physlcian: The I h. After this certificate ha funeral director, page	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐	LER/Outnatie		6. Place of Death		ne) ence 6 □Other (S	pecify)		
J Of	ng Phy ter this neral d	n: To	27. Manner of Death 1 Privatural 5 Pending (Month, Day, Year)	28b. Time o				ow injury occurred	респу		
sioi	Attending ir death. ector: After by the funer	catic	2 Accident investigation		M 1 □Yes	s 2□No	Of Leastion (C	the at and Mumber or	Pural Pauta Number		
Div	i gete	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At he building, etc. (Specif	fy)	reet, factory, office		City or Tow		Rural Route Number,		
	To the Hospital or Atten within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knot 2 Medical Examiner: On the basis of examina and manner stated.	owledge, deat ation and/or in	th occurred at the time, nvestigation, in my opini	date and place, ion, death occurr	and due to the ded at the time, d	cause(s) and manner date and place, and c	as stated. lue to the cause(s)		
	To th withir To th comp	Me	29b. Signature and title of certifier MD		29c. License nu		2	29d. Date signed (Mo	onth, Day, Year)		
				00.175	RESU			05/29/2			
	3		30. Name and address of person who completed cause of death (Iter SABAEVA ELENA, 560/ LOCH R	n 23a) (Type,	BLUD, BAL	TIMORE	MD	21239			
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signal 100 0 3 2009	ature par							

DHMH 17 Rev 1/2001

JONES, KEVIN

09-04153 Hardy Jones Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Physicia	ın/	1. Decedent's Name (First, Middle,L					2. Date of Death		3. Time of Death
Medical Exami	ner		ones		4. Oh. T		Month 1 May 25, 200	9 4c. County of De	0643 hrs
€		 Facility Name (if not institution, g 3200 blk Noble Street 	give street and number)		4b. City, Town, or Lo Baltimore	ocation of Death		4c. County of De	1/1
Funeral			Sex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24Hrs.	8. Date of Birth		Birthplace (State or Foreign
Director		212-02-7564 1	/M 2 F 26	Yrs	Months Days	Hours Min.	Aug 29,		Country) Maryland
		Usual Residence of Decedent					114921	- 10 2	
v any		10a. State 10b. County		y, Town or Locat					10d. Inside City Limits 1 Yes 2 No
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ne Maryland or 28a-f show <u>fied at once.</u>	Director	10e. Street and Number			10f. Zip Code	- 11	10g	o, Citizen of What C	
with the Maryland is 23a or 28a-f she		11. Marita Status	2 Circle 12. Was Decedent Ever in L	10 42 W	as Decedent of Hisp	224	ocify Voc or No		nerican Indian, Black,
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral	1 Never Married 2 Marri	ed Armed Forces?		es, specify Cuban,			White, etc	
		3 Widowed 4 Divorc	1 Yes 2 No	1	Yes 2 No	specify:		Specify:	lack
5-0036 led within 72 hours after tygene. other than "natural", c	g p	15. Decedent's Education (Specify	only highest grade completed)	16a. Deceder	nt's Usual Occupation	on (Give kind of w	ork done	16b. Kind of Busine	ss/Industry
36 n 72 h nan "r ical E	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		KLIFT		1	Good.	- Ice Cream
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nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after nt of Health and Mental Hygiene ut: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner		Jeannette /							14 21224
ore, M ss l and 2 of Health If item 2		20a. Method of Disposition 1 Burial 2 Cremation			sition (Name of cem- ther place)	-		20c. Location - City	
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Baltimore, permit. Pages I a Department of He Important: If ite injury or other tr		21. Signature of Funeral Service Lic	ensee M. C. L. C. C.	22.1	Runaly	of Facility A. Ha	you f	uresal ;	oun, MD Senne My 21229
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/Medical		failure. List only one cause on			, ,				Between Onset and Death
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	ine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence c.	of):					
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Box 68 e death certif the attending	sicia	1 Yes 2 No 9 Unkno	4 Pregnant at time of c	death	ther (Specify)				
. 4 >4	Physician	Part II. Other significant condition	9 OIKIOWII	resulting in the	underlying cause di	iven in Part I	23e. Did tob	acco use contribute	e to the cause of death?
Division of Vital Records, P.O. Spital or Attending Physician: The law requires that thours after death. neral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be dene	ē	Tarti. Other significant condition	contributing to death but not	resulting in the	underlying cause gr	ivoir iii r dicti.			Probably 4 Unknown
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of \officers	-	27. Manner of Death	28a. Date of Injury FOUND:	28b. Time of	Injury 28c. Injury	y at Work?		ow injury occurred	
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Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director.	ical	29a. Certifier 1 Certifying Physical Cone) Certifying Physical Examination (Check only)	sician: To the best of my knowle ner:On the basis of examination	edge, death occu	irred at the time, dat ation, in my opinion.	te and place, and death occurred a	due to the cause at the time, date a	e(s) and manner as and place, and due	stated. o the cause(s)
To t with To C	Medical	29b. Signature and title of certifier	and manner stated.		29c. License			29d. Date signed	
		Demost QS	railhaill mx		O.C.N			May 25, 2009	
	ŀ	30. Name and address of person wh	no completed cause of death (Ite	m 23a)					
		Pamela E. Southall, MD			11 Penn Street	, Baltimore, I	MD 21201		
		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	11				
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DHMH 17 Rev 1/20	001			ÖRIGINA	AL.		^^	14.40	

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 29, **Physician** 2009 10:04 AM Willard J. Kling May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Holy Cross Hospital Montgomery Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year April 23, 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Year) 1915 New York 1 X M 2 □ F 94 Director 106-09-1555 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ral", or items 23a or 28a-f show 1 Yes 2 No Director New York Erie Amherst 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 348 North Elliott Creek Road 14228 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify þ 3 Nidowed 4 Divorced Completed traumatic event, the Mudical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Paint/Design t of Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Kling Marion Mittlesteadt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willard J. Kling, Jr. (Son) 348 N. Ellicott Creek Rd., Amherst, NY 14228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Iter 1 X Burnar 2 ☐ Cremation 3 ☐ Removal from State Injury 6/4/09 4 Donation 5 □Other (Specify) Acacia Park North Tonawanda, NY 22. Name and Address of Facility Hilliard-Creasey Funeral Home, Inc 21. Signature of Funeral Service Licensee 147 Delaware St., Tonawanda, NY 14150 Mun 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a. Aspiration Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner b. Hepatorenal Failure Sequentially list conditions Examine Disa to for as a nonsequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed End-Stage Dementia attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ sign I be Glaucoma, Adult Failure to Thrive 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Hypothyroid Were autopsy findings available prior to completion of cause of has page 2 autopsy perform certificate 1 ☐ Yes 2 No 1 □Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending s after death.

1 Director: After in by the fur investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Box 68760 P.0. Division of Vital Records,

or Attending within 24 hours a

To the Funeral I

completely filled

State

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

(Check only one)

Medical

Barbara Sapanich, MD 32. Pegistrar's Signature

and manner stated.

Suparuch, Rem, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1500 Forest Glen Rd., Silver Spring, MD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0065485

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY Day (1. 11:35AM HELEN JEAN KOZAK 4c. County of Death timore 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 □ M 2 🔀 F 212-36-7514 /11/1939 MARYLAND 70 Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b, County 10c. City, Town or Location 1 ☐ Yes 2 No MD BALTIMORE GLEN ARM 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 11734 GLEN ARM ROAD 21057 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc 1 □Yes 2 □ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No 1 ☐ Yes 2 📉 No Specify: Specify. WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9TH GRADE HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HELEN E. BOULDIN GEORGE E. WILHELM 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 TIMBER CREEK CT. ESSEX, ROBERT KOZAK/SON 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) DULANÉY VALLEY MEM. 6/3/2009 COCKEYSVILLE, MD 21. Signal re of Funeral Service Licensee THE JOHNSON FUNERAL HOME, P.A. MO1139 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SEPSIS Due to (or as a consequence of) RENAL FAILURE Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 **N**No 1 ☐ Yes 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

/Medical Examiner requires that the death certificate be executed ng physician and as the burial-trans attending p for use as signed by the a d be detached f o σ. Records, page 2 has certificate of Vital Physician: this funeral After Division To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu death.

Physician

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Funeral

Director

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ital Hygiene. d other than "natural", or items 23a or 28a-f shov event, the Medical Evanting must be notified at

filed within 72 hours after death with

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Physician

Pages 1 ⊓ent of № Department of Important: If it any injury or o

Maryland 21215-0036

Baltimore,

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ģ RESPIRATORY FAILURE Completed 25. Was case referred to medical examiner? Be 1 Yes 2 ₹No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 🗹 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature 29d. Date signed (Month, Day, Year) 29c. License number D53593

State Registrar OSLER DRIVE TOWSON,

7601

32. Registrar's Signature

MARYLAND

21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. D.

MOSTAFA,

ASHRAF

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year William Germanus Knoerlein 9:40 05 28 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Franklin Square Hospita
5. Social Security Number 6. Sex 7. Age (Ir Baltimore Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 1**X** M 2□ F Months Days Hours Min. 213-30-1364 29,1932 <u>Maryland</u> Usual Residence of Decedent 10b. County 10a. State 10d, Inside City Limits 10c. City. Town or Location 1 ☐ Yes 2 No Maryland Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21128 9601 A Haven Farm Road United States 12. Was Decedent Ever in U.S. Armed Forces? NOTES 2 □ No If Yes, Give Year or Dates: 1950-54 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ∐Yes 2/CXNo Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4or 5+) Post Office Letter Carrier 11 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Germanus L. Knoerlein Marie T. Trompetter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9601 A Haven Farm Road Perry Hall, MD Virginia Knoerlein (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial ② Cremation 3 □ B Hilltop Service Corp; 5/30/2009 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Fun Duda-Ruck Funeral Home of Dundalk, Dundalk, Maryland 7922 Wise Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or freart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Finai egionella disease or condition resulting in death) Due (or as a consequence of) Due to for as a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 MNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 □Yes 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Injury at Work? 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner Examiner Hospital or Attending Physician: The law requires that the death certificate be executed

Physician

Examiner

Funeral

Director

28a-f show

23a or death with

or Items

permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Item any injury or other traumatic event, the Medical Experiment once.

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Registrar

Division of Vital Records, P.O. Box 68760,

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Sequentially list conditions, If any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RESOCOC 05.28.2009

Baltimore, Maryland 21237

DHMH 17 Rev 1/2001

9000 Franklin Square Drive.

ford

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHRIVATSA NADIGER

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Ko₁b Charles Edwin 1:00 PM May 29, 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Baltimore Co. Dundalk 7907 St. Claire Lane If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 X M 2 □ F 74 14, Maryland 1935 219-32-2106 Director Feb. Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 27 Is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at Dunda1k 1 ☐ Yes 2 XNo Director Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7907 St. Claire Lane 21222 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify. \$ 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 in and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Steel Industry Steel Worker 8 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Ments Important: If Item 27 Is marked any Injury or other traumatic ev Theresa Alexander Robert Kolb 19a. informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dundalk, Maryland 7907 St. Claire Lane Mrs. Lois J. Kolb (Wife) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 6/2/2009 Towson, Maryland 4 ☐ Donation) 5 ☐ Other (Specify) 21. Signature of Funeral Service Lices 2D Name and Address Figure ral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** uncer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ner certificate be executed Exami and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the Se use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy The law requires that the death Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown as been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has N autopsy performed? 1 \(\text{Yes} \) 2 \(\text{KNo} \) page 2 No 1 Tyes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2**X** No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes ဥ 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending investigation М 1 ☐ Yes 2 ☐ No death. 2 Accident Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a

To the Funeral E Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signat 641 4940 Eastetn Ave. 30. Name and address of o completed cause of death (Item 23a) (Type, Print) Johns Hopkins Bayview Med. Ctr. Alfredo Quinones-Hinojasa 21224 Baltimore, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Back Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2009

Baltimore

White

Birthplace (State or Foreign Country)

10d. Inside City Limits

1X Yes 2 No

1:45pM

1. Decedent's Name (First, Middle, Last) 2. Date of Death 31^{Day} May Month **Physician** Geraldine League /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northwest Hospital Center Randallstown 8. Date of Birth June 10, 1925 If Under 1 Year | If Under 24 Hrs. Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** Months 219-18-6584 83 Days Hours 1 □ M 2 🔀 F Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at Howard City Director MD Ellicott 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9814 Gwynn Park Drive 21042 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify: þ 3 Widowed Williams Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event. College (1-4or 5+) Elementary/Secondary (0-12) 12 Claim's Processor Helathcare 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Christian Wuestner Lillian 2 19a. Informant's Name/Relationship (Type. Print) Linda C. League / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place are cemetory) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 6/2/2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sprvice Licenses Dorota Marshall ME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** REPRATORY FAILURE /Medical Due to (or as a consequence of): Examiner ACUTE EXACERBATION OF CITHOMC Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) that the death certificate be executed sician and burial-trans OBSTRUCTIVE LING DISEASE Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) P.O. 9 Unknown 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 Completed 24a. Was an has autopsy page performe certificate 1 ☐ Yes 2 No Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After th funeral 27 Manner of Death 28b Time of 28a. Date of Injury 28c. Injury at Work? or Attending (Month, Day, Year) 1 Natural 5 Pending investigation ours after death.

leral Director: A
filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital o within 24 hours aff To the Funeral Di

Dekowski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9814 Gwynn Park Drive, Ellicott City, MD 21042 20c. Location - City or Town, State Hanover, MD 22. Name and Address of Facility
Maryland Cremation Services
PO BOX 1413, baltimore, MD21203 Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 MOther (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 145931 Smith Avanua Sufe 203 Baltimara MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 Debbie Burton 31. Date filed (Month, Day, Year)

Registrar

State

completely

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year May 22, **Physician** 2009 PM11:15 Mary Carolyn Lineburg /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's 905 Glacier Avenue Capitol Heights If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day) **Funeral** Months Days Hours 1 □ M 2 🔽 F Yrs. 579-32-9245 Maryland **Director** 81 May 29, 1927 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a freedest Exeminar must be notified at 1 ☐ Yes 2 X No Directo Virginia | Frederick Middletown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 22645 U.S.A. 377 Chapel Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married 1 □Yes 2 No ò Specify: 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Medical Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Manson James Lineburg Mary Carolyn Fainter ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 905 Glacier Ave., Capitol Heights, MD 20743 Department of Health Important: If item 27 any injury or other troone. Brian Sarns (Son) 20b. Place of Disposition (Name of Shenandoan 20a. Method of Disposition 20c. Location - City or Town, State 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 05 - 26 - 095 ☐ Other (Specify) Memorial Park Winchester, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Stover Funeral Home 177 N. Holliday St., Strasburg, VA 22657 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** METASTATIC CARCINOHA BREAST disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CARCINOMA BREAST Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and Director: After this certificate Seen signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Day 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 □ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 ☐ Yes 2 📉 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 🔀 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated To the 1 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Do013668 5-28-09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

Azher Hussain, M.D.

JUN 0 3 2009

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760.

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of Vital Records,

Division

32. Registrar's Signature

4917 Edgewood Road College Park, Maryland 20740-1439

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No. Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Day 6:35 Physician Ellen White Logan 2009 May 30. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 87 1 □ M Director 1/14/1922 Washington DC 578-38-2027 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at MD 1 ☐ Yes 2 No Director Montgomery Rockville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 72 hours after death with ò 303 Adclair Road 20850 USA 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items, 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: White þ Specify: 3 ☐ Widowed 4 Soivorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Professional Association Administrator marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Mental em 27 is marked o 2 Jarrett Carlisle White Jane Langtry Morgan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) H. Marshall Peter, son 2602 Agate St. Eugene, OR 97403 permit. Pages 1 and Department of Health Important: If item 27 any injury or other th 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 6/1/2009 Beltsville, MD 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. 21. Signature of Funeral Service M01539 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia /Medical Due to (or as a consequence of): **Examiner** Chronic Kidney Disease Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2XNo P.0. the 9 Unknown 9 🗆 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate 2 No 1 □Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No npatient 2 ER/Outpatient 3 DOA Certification: To this After thi funeral of 27. Manner of Death . Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural hours after death.

uneral Director: A

ely filled in by the fi death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide thin 24 hours aff the Funeral Di mpletely filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 2 To the I and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DOO67782 JAWAD ARSHAD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Center Drive Rockville, MD 20850 Jawad Arshad MD 9901 31. Date filed (Month, Day, Year) State JUN 0 3 2009 Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TEM# 30 per DVR, G892, 673709, WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Burdett Clarence Moreland 1 4 1 June 3, 2009 6:35 ам 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Ougen Anne's Stevensville 207 Penny Lane 8. Date of Birth (Month, Day, July 3, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 6 Sex Months Days Hours Min 214-66-4397 1 XM 2 ☐ F `52 1956 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Stevensville Queen Anne's 1 Nes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 207 Penny Lane 21666 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo White Specify If Yes, Give Year or Dates: US Marines Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner Operator Food Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clarence B. Moreland Laola Chaney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sharon E. Moreland / Wife 207 Penny Lane, Stevensville, MD 21666 Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ardent Crematory or other place) 6/4/2009 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) Dorota Marshall 22 Mary land of Cremation Services PO Box 1413, Baltimore, MD 21. Signature of Euneral Service Licensee MD 21203 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CIVER disease or condition resulting in death) Fasilune VERNO Due to (or as a consequence of) corrhosi Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Day Year 5 Other (specify) a I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 No 3 Probably 4 Hriknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 □ Yes 2 □ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

burial-transi and attending physician for use as the burial Box 68760, The law requires that the death certificate be P.O. the detached signed by t d be detach Division of Vital Records, funeral director, page 2 should peen has certificate e Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certifice the completely filled in by within 2

Physician

/Medical

Examiner

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Director

Funeral

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Completed

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Certification: To

Medical

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Registrar

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Director

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any Injury or other traumatic events.

Physician

/Medical

Examiner

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 2 Accident 3 Suicide 4 Homicide 1 🔛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License numbe

6374

and address of person who completed cause of death (Item 23a) (Type, Print)

Centreville, Md. 21617

29d. Date signed (Month, Day, Year)

09

Jeffrey L. Ukens 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

JUN 0

2540 Centreville Road Registrar's Sign

J. Vilens

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend \$7 per FH G892 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra: Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** EVELYN MARIE NICHOLSON JUNE 2009 3:20 A. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 500 VIRGINIA AVENUE APT. 910 BALTIMORE Birthplace (State or Foreign Country) If Under 1 Year 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🙀 F 86 Yrs WEST VIRGINIA 4/29/1923 Director 220-12-7468 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a. State Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 No Director BALTIMORE TOWSON 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code 21286 Funeral 500 VIRGINIA AVENUE APT. 910 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be fifed within 72 hours after. Health and Mental Hygiene. em 27 Is marked other then "natural", or Ite 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify. ģ 3 ☑ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12TH GRADE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be PORTER WILLIAMS ZEPPA UNAVAILABLE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JUNE M. DAWSON/ 2622 EDGEMERE AVE. SPARROWS POINT, MD of Health Item 27 NIECE 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 nent of H ant: If Ite MARSHVILLE BAP. CH. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or once. CEMETERY 6/5/2009 MARSHVILLE. 21. Signature of Funeral Service Licensee MOO2 17 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cane **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, to the cause. Enter Underlying Cause (Disease or injury Due to (or as a cons ≪ uence of): Examiner The taw requires that the death certificate be executed physicien and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending p 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the at d be detached fo 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacce use contribute to the cause of death? ģ 189Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2∏ No 1 Yes 2 1 No 1 Yes funeral director Be 25. Was case referred to medical examiner? 26. Place of Death | Check only | Te Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier mo 30. Name and se of death (Item 23a) (Type, Print) 160 Wav 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

<u>JUN 0 3 2009</u>

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			 1- For State Registrar Decedent's Name (First, Middle, I 		Certificate o	t Death	2. Date of Deat	g. No.	3. Time of Death		
Me	Physici dical Exami						Month May 24, 20	Day Year	0453 hrs		
AT	· 4		Shepherd Lamor 4a. Facility Name (if not institution,			4b. City, Town, or Location		4c. County of Death	1		
.6			7100 Coastal Highway,	Room 114		Ocean City		Worcester			
	Funeral		5. Social Security Number 6	. Sex 7. Age	(In yrs. last birthday)			th(MM/DD/YYYY) 9. Bir	in		
	Director		217-08-9124	X м 2 F	39 Yr	s. Months Days Hour	s Min. Nov.	22, 1969 6	untry) NY		
	y		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Loca	tion			10d. Inside City Limits		
	ow any		MD N/A		ioc. City, Town or Loce	Baltimore			1 X Yes 2 No		
5	ryland a-f sh	ફ	10e. Street and Number			10f. Zip Code	1	0g. Citizen of What Cou	ntry?		
200	he Ma or 28 fied a	Director	706 Eaton Stree	et		21224		United St	ates		
2	eath with th items 23a ust be noti	Funeral [11. Marital Status 1 X Never Married 2 Marr	12. Was Decedent E Armed Forces? 1 Yes 2	Ever in U.S. 13. W	as Decedent of Hispanic Or Yes, specify Cuban, Mexica		- 14. Race - Amer White, etc.	ican Indian, Black,		
	ifter d il", or	by Fu	3 Widowed 4 Divor	ced If Yes, Give Year	1	Yes 2 X No specify	y:	Specify: Whi	.te		
	ours a	q p	15. Decedent's Education (Specif			nt's Usual Occupation (Give		16b. Kind of Business/	Industry		
	036 within 72 h ene. er than "r d di al E	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	+)	ortgage Broke	er	Mortgage			
	21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the M dira	Be	17. Father's Name (First, Middle, L Albert B. Newm	an	er's Name (First, Middle, I hyllis Raem		- Zin Codo\				
	MD 2 rd 2 shoul- lith and M m 27 is m aumatic e	To	19a. Informant's Name/Relationshi Shannan Anders	er, City or Town, State, Zip Code) Et, AZ 85233 20c. Location - City or Town, State							
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 Xcremation 4 Donation & Other Spe		te Atlantic	sition (Name of cemetery, other place) Crematory	5-29-2009	Glen Burr			
	Baltin permit. Departm Importa		21. Signature of Juneral Service L	TODA	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Name and Address of Facil 328 Sulphur S	Spring Rd.,	Arbutus, M			
	Physician /Medical xaminer		23a. Part I. Enter the disease, or confailure. List only one cause of Immediate Cause (Final disease	n each line.		the mode of dying, such as and zolpidem			Approximate Interval Between Onset and Death		
	Valilillei		or condition resulting in death) Sequentially list conditions,	Due to (or as a conse							
		xaminer	cause. Enter Underlying Cause (Disease or injury that initiated								
	xecuted n and - transit	nii l	events resulting in death) Last	d.							
	e exection a	ledical	X UNPENDED	AMENDED 238	1,2/28a-1,p	ermE,. g892	6/1//09 IT				
	Division of Vital Records, P.O. Box 68760, within 24 hours after details Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	sician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	4 Pregnant at	2 F	Tetal death 3 Ector	pic pregnancy	23d. Date of delive Month	ry Day Year		
	P.O. B es that the de igned by the be detached to	by Phy	Part II. Other significant condition		but not resulting in the	underlying cause given in I		obacco use contribute to			
	ords, aw requires as been sig 2 should be	ompleted					24a. Was		utopsy findings available completion of cause of		
	Rec The L icate h	Com					1 🗸 Yes		res 2 No		
	cian:	Be (25. Was case referred to medical examiner?	Hospital:		IOther:	th (Check only one)	Dudan e den	an Saana		
	f Vi Physi er this	2	1 ✓ Yes 2 No 27. Manner of Death	1 Inpatie			Nursing Home 5	Residence 6 Oth	er: Scene		
	no ding h. Afte	on:	1 Natural 5 Pendir	(Month, Day, Ye	ear)		1	non injury coodings			
	Division of Vital Records, tal or Attending Physician: The law requirers after deart. After this certificate has been sited in by the funeral director, page 2 should be	ertification:	2 Accident Investi 3 Suicide 6 X Could determ	gation 28e. Place of Inj	+/09 Fd 4:4 oury-Athome, farm, stround in mot	eet, factory, office building,	etc. 28f. Location	(Street and Number or F State) 7100 Coa Ocean City	Route Number, City		
	he Hospita in 24 hour he Funera	edical Ce	29a. Certifier 1 Certifying Phy	rsician: To the best of my	/ knowledge, death occ	urred at the time, date and pation, in my opinion, death	place, and due to the cau	se(s) and manner as sta	nted.		
	Tot with Tot	Medi	29b. Signature and title of certifier	and manner stated.		29c. License numbe		29d. Date signed (M			
1		-	Theoden !	U Kird	JR, m.	0.C.M.E.	OCME	May 25, 2009			
-	/		30. Name and address of person w	ho completed cause of d	eath (Item 23a)	to a			_		

111 Penn Street, Baltimore, MD 21201

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Registrar

State 31. Date filed (Month, Day, Year)

Theodore M. King, Jr., MD. Assistant Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Łast) Dav **Physician** 2009 MA 28 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Baltimor, mi It'more Ci Johns Hopkins
5. Social Security Number Bayvien Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday Date of Birth (Month, Day, **Funeral** Days 1 ₩ 2 □ F 216216695 5 Yrs. Maryland murch Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Modical Examiner must be notified at 1 ☐ Yes 2 🛣 No Dunda1k Director Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1708 Brookview Road United States 21222 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 🛣 No Maryland 21215-0036 If Yes, Give Year or Dates White 1 ☐ Yes 2 ₩ No Specify þ 3 ☐ Widowed 4 K Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Evergreen Security 12 should be filed w h and Mental Hygier 7 is marked other th Security Guard 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carol S. Champ Van J. Northington traumatic ပ Department of Health and Important: If item 27 is maan any injury or other traumat once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mother 780 Blue Springs Road Elizabethton, TN 37643 Mrs. Carol S. Northington Baltimore, 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ₺ Burial 2 ☐ Cremation 3 Removal from State 5 ☐ Other (Specify) 6/2/2009 Randallstown, MD **a**keview Cemetery 4 Donation 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7022 Wise Ave. Dundalk, Maryland 21222
Appro 21. Signature neral Service 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** d /Medical Due to (or as a consemence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) P.O. Box 68760, ned by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown sate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes No 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 □ No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Mcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier Medical On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2☐ Medical Examiner: and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

2

State Registrar

JUN 0 3 2009

31. Date filed (Month, Day, Year)

Johns Hopking

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Filer, mD

NION 4940 Easter Huy

4277 cella Phillips	aı	Please Type or Print in Black Indelible Ink. Ensure All the Per State 89 Mary and Perfertment of Health and Me	ntal Hygiene
.0110 1 11111111	1-	For State Certificate of Death	Reg. No. 3. Time of Death
Physicia	ın/ 1	Decedent's Name (First, Middle,Last)	Month Day Year 0712 hrs May 29, 2009
ical Examir		Vonzella Maria Phillips a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location	n of Death
		Anne Arundel Medical Center Annapolis	Anne Arundel nder 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Funeral		Social Security Number 6. Sex 7. Age (III yis: last birthday) Months Days Hot	Foreign
Director	L	216-78-0549 1 M 2XF 44 Yrs. World 27	00,11,100
ny	-	Sual Residence of Decedent Oa. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
nd how a ce.	_	MD Anne Arundel Annapolis	1 X Yes 2 No
farylar 28a-f s I at on	Director	0e. Street and Number 10f. Zip Code	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland permit regres I and A Schould be filed within 72 hours after death with the Maryland Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	흐	3016 Arunde1 on the Bay Road 21403	U.S.A. Orioin? (Specify Yes or No- 14. Race - American Indian, Black,
tth with	Funeral	1 Never Married 2 X Married Armed Forces? If Yes, specify Cuban, Mexic	can, Puerto Rican, etc.)
ter dea	Ē	Wildowed 4 Divorced If Yes, Give Year 1 Yes 2 No spec	offy: Specify:
ours af atural xamin	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (G during most of working life. DO N	ive kind of work done IoT use retired) 16b. Kind of Business/Industry
n 72 h nan "n ical E	plete	Elementary/Secondary (0-12) College (1-4 or 5+) 2 Manager, Assiste	d Living Housing
-003 1 withi rgiene. ther the	Completed	17. Father's Name (First, Middle, Last)	ther's Name (First, Middle, Maiden Surname)
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	John Highe	rah Hicks Number or Rural Route Number, City or Town, State, Zip Code)
21 hould nd Men is man	은	19a. Informant's Name/Relationship (Type, Print) Geoffrey L. Phillips/Husband 1802 Cedar Driv	
Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important: If Item 27 is injury or other traumatingury or other traumati		20a Method of Disposition 20b. Place of Disposition (Name of cemeter)	Date 20c. Location - City or Town, State
Ore iges 1 a it of H it If it other		Burlal 2 X Cremation 3 Removal from State	s 06/03/2009 Hanover, Maryland
ultim nit. Pa artmer oortan ry or		22. Name and Address of Fa	acility Ardent Cremation Services
Ba perr Dep Imp inju		Laura C. Hardlesty MO 1197 7522 Connelle 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such	by Drive, Ste.N, Hanover, MD 21076 se cardiac or respiratory arrest, shock, or heart Approximate Interval
Physician Medical			
aminer		Immediate Cause (Final disease or condition resulting in death) a. Pulmonary Thromboembolism due to deep leg or condition resulting in death) Due to (or as a consequence of):	g veni unombodio
		Sequentially list conditions, b.	
	iner	If any, leading to immediate cause. Enter Underlying Cause	
_ #	Exam	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
cecuted n and - transit	calE	d. UNPENDED AMENDED	
60, e be ex ysician burial	ĕ	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funcari Director: After this certificate has been signed by the attending physician and managed filed in the funcal director name 2 should be detached for use as the burial - transit.	Physician/Medi	23b. Was decedent pregnant in the past 12 months?	ctopic pregnancy Month Day Year
ox 6 eath ce attend for use	sici	1 Yes 2 No 9 V Unknown 9 Unknown	
D. B t the d by the ached	l F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	n in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✔ No 3 Probably 4 Unknown
, P.O. res that the signed by be detacled	d by		24a Was an 24b. Were autopsy findings available
Division of Vital Records, tal or Attending Physician: The law require as after death. By Director: After this certificate has been sind in by the funeral director nage 2 should be lad in by the funeral director nage 2 should be a should as a should as a should be a sh	Completed		autopsy prior to completion of cause of death?
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tal Rection: The certificate	S S	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Oth	Death (Check only one) er; Nursing Home 5 Residence 6 Other:
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vision of or Attending Photoe for death. Director: After in by the funeral	Certification: T	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office build	ling, etc. 28f. Location (Street and Number or Rural Route Number, Cit or Town, State)
Div pital or purs affi eral D	Talled Talled	determined (Specify)	the squar(a) and manner as stated
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director:	retely 1	29a. Certifier (Check only one) 29a Medical Examiner: On the basis of examination and/or investigation, in my opinion, de	and place, and due to the cause(s) and mariner as stated. eath occurred at the time, date and place, and due to the cause(s)
To the To the To the	complete	29b. Signature and title of certifier 29c. License n	
	2	0.C.M.	E. May 30, 2009
, · · ·		30. Name and address of person who completed cause of death (Item 23a)	
IV		Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Balt	imore, MD 21201
1-	Stat	31. Date filed Worth, Day Year 32. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 1 - For State Registrar Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Ja Day 02 200 4c. County of Death Town, or Location of Death 4a. Facility Name (If not institution, give street ommynicare altimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yes. last birthday, Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) unk Social Security Number Days Months 1**∑**M 2□F 59 215-54-2208 Dec 18, 1949 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1√ Yes 2□No MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 4017 Liberty Heights Avenue 21207 USA 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? unk Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: white 3 Widowed 4 Divorced 16b. Kind of Business/Industry unk 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward Parker Melvina Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4017 Liberty Heights Avenue Baltimore, MD 21207 Communicare at Liberty Heights Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 🛛 Other (Specify) in state 21. Signatule of Lineral Scice Licens Non S. Wards, 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Mirector Baltimore, MD 21201

23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acquired mmune CLAPTES Due o (or as a cons nuence of): Due to for as You sequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last accinoma Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 XYes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? (Month, Day Year) Injury 5 Pending investigation 1 Natural 2 Accident

Physician /Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Physician

Examiner

Funeral

Director

ral", or Items 23a or 28a-f show Examiner must be notified at

2 should be filed within 72 hours after death with n and Mental Hygiene.
Is marked other than "natural", or Items 23a or :

Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natur any Injury or other traumatic event, the Medical once.

altimore, Maryland 21215-0036

Pages 1 and 2

Director

Funeral

Completed by

Be

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/Medical

Physician/Medical Examine the burial-transit physician attending ph for use as t certificate has been signed by the rector, page 2 should be detached ş Be Completed director, this After 1 within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

9040430

Certification: To

IF FEMALE:
23b. Was decedent pregnan
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 □ Unknown

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier

D15503

29d. Date signed (Month, Day, Year) May 3, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

501 Dolphin Street, Baltimore, MD 21217 Amatun N. Maeem, M.D.,

State Registrar

Medical

31. Date filed (Month, Day, Year) JUN 0 3 2009

79/in

6 ☐ Could not be

determined



Necesia

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** Lois E .. P1umb 8:00 PM May 27, 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Co. Parkville 9003 Weathervane Garth If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Virginia 1 □ M 💥 □ F 86 Oct. 8,1922 229-14-7170 Director Usual Residence of Decedent 10d, Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b County 10a. State "natural", or items 23a or 28a-f show wilce! Examiner must be notified at Parkville 1 ☐ Yes 2 ANo Baltimore Director Maryland 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 9003 Weathervane Garth United States 21234 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2K No Yes. Give Specify: Completed by White 3 N Widowed 4 Divorced Year or Dates. er than "natura the Medical E 16b Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Machine Operator 12 Years is marked other 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any liny or other traumatic event once. 17. Father's Name (First, Middle, Last) Be Susanne Monger Daniel A. Eppard ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 1768 Tank Road Finksburg, MD Brenda K. Stewart (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gdns. 5/30/2009 Middle River, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatury of uneral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 sease, occomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death 23a. Part 1. Enter the dis shock, or heart falls Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Stenosi tic Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-trans Due to (or as a consequence of): Physician/Medical the attending p ves, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ∏Yes 2 No ed by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Des 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performs 1 ☐Yes 2 ☐No certificate 2 Nin 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Aesidence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Box 68760. P.0. Division of Vital Records,

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, p. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N Charles Baltons mg 6BMC R 5103 6767 Farendu 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 10:50A M **Physician** Anna Pruett May 30 2009 Joan /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Square Hospital 8. Date of Birth (Month, Day, Year) Sept. 23,1932 7. Age (In yrs. last birthday, **Funeral** Months Days Min 1 □ M 21 F Pennsylvania 205-24-3469 76 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10b. County 10c. City. Town or Location 10a. State nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan actment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Wedical Event is a cust be notified at 1 Tyes 2XXXIII Director Rosedale Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21237 United States 8222 Dorset Ave. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No Specify: White 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4or 5+) Coast Guard 12 Years Years Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rose Dolan Charles Sanders ပ Step 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau 8222 Dorset Ave. Rosedale, Maryland 21237 Mr. Arnold Pruett, Sr. Son Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Hilltop Service Corp. 6/2/2009 Towson, Maryland 4 Donation 5 ☐ Other (Specify) neral Service Licenses Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 21222 7922 Wise Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usaase in figury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-tran attending physician and Due to (or as a consequence of) Physician/Medical as the IF FEMALE for use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) □Yes 2□No the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Disease director, page 2 should Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed O.P certificate 1 ☐ Yes 2 ☐ No D 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, death.

Baltimore, Maryland 21215-0036

24 hours after death Funeral Director: filled in by the

6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

1 ertify ng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signatur title of certifie 29c. License number

30. Name and dress of person w mpleted cause of death (Item 23a) (Type, Print)

9000 Franklin Square Drive, Baltimore Mai 21237 Dr. William 31. Date filed (Month, Day, Year)

State Registrar

Medical

within 2.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND #7 PER FH G892+6/11/09(3)H/ Department of Health and Mental Hydiene.

			AMEND #7 PER PH G	State of Mai	*	epartment of F Certificate of I		-	Reg. No.	009	17	762
			1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year	3. Time o	of Death
	Physici: /Medic		Dorothy Pass-Robbi	ins				05	28	2009	7:45	РМ
	Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or	Location of Death		4c. Co	unty of Deat	h	
		•	Sanctuary at Holy	Cross		Burtonsv	ille		Mon	tgomer	ry	
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birth	day) If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	9. Birt	hplace (State	or Foreign
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	ath 9 23	rai	4800 East CApitol			20019	0-1-1-2 (0-	4 - 1/ 1/-	U.S.A	Race - Ame	rices Indian	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Heelth and Mental Hygiene. Item 27 is marked other than "natural", or Itema 23a or 28a-f show other traumatic event, Ita Medical Examinat must be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Evarmed Forces? 1 ☐ Yes 2 ☐ Note of Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cubs 1 ☐ Yes 2 X No	Ispanic Origin? (Sp in, Mexican, Puerto Specify:	Rican, etc.)		Black, White	e, etc.	
2	72 hc natu	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)	16a. D	ecedent's Usual Occup	ation	ina	16b. Kind	. Kind of Business/Industry		
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2	or the	5	2	years	DC	General Hos	pital		Nurse			
9	be filed tal Hygird other	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle	, Maiden Su	mame)		
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ar	2 should to and Ment is marked raumatic e		19a. Informant's Name/Relationship (Ty	al Route Numb	Number, City or Town, State, Zip Code)							
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ē,	is 1 and 2 of Heelth a item 27 is other tran		20a. Method of Disposition		20b. Place of D	Disposition (Name of crematory or other place	(a)	Date	20c. Locat	tion - City or	Town, State	
altimore,	permit. Pages Department of Important: If it any Injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	-	Mt. 01:	ivet	06/06	5/2009		ngton		
Ba	Depar Depar Impor any In		21. Signature of Funeral Service License	Mberia	,	22. Name and Addre						
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	Physician		Immediate Cause (Final			Onset and						
۱	/Medical		disease or condition resulting in death)	Sepsis	consequence of	١٠.						
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	ted nsit	in	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
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P.O. Box	that the death certifined by the ettending I	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown			230	d. Date of del Month	livery Day	Year			
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ords,	law requires that the as been signed by th 2 should be detache	ted by						10	Yes 2□ñ	4o 3□Pr	robably 👯	Unknown
Division of Vital Records,	The ete h page	Completed						24a. Was auto perfo 1 \(\text{Yes}	psy ormed?	prior to death?	utopsy finding completion of 200 No	s available cause of
=======================================	Physician: Th r this certificete ral director, pag	Be	25. Was case referred to medical examiner?				26. Place of Deal	h (Check only	one)			
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Dİ <u>X</u> i	2 9 2 2	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injur building, etc.	y - At home, farm (Specify)	n, street, factory, office			Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical C	29a. Certifier 1 X Certifying Physical Control only 2 Medical Examination	sician: To the best of ner: On the basis of e and manner state	examination and	death occurred at the tir or investigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and pla	id manner as ace, and due	s stated. e to the cause	e(s)
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			12) ,		ם חסת	4566		06/02/	/2009		
			30. Name and address of person who co	ompleted cause of de-	ath (Item 23a) (T		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		/ - / - /		,	
		l	Sunitha Bhogavilli				Silver S	oring.	MD 209	902		
	Sta	to	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	onde #1-1/	DITACT D					
	Registr		IUN 0 3 200	19 Drews	A. ,	pare						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh g892 6-18-09 yt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Roberta 28 POOS MA OPOL /Medical give street and number) City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution Examiner Candallstown Mou Tome If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 4Month, Day, 5. Social Security 94725 9. Birthplace (State or Foreign 6. Sex 7. Ane (In vrs. last birthday) **Funeral** Months 1 M 2 M 78 Yrs. 213-26-442 Director lary Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Event in a maint be motified as 1 DYES 2 No Director timore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 14519 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 lac If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ 100 Specify 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired). is marked other than College (1-4or 5+) Elementary/Secondary (0-12) a orker 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) Be nallwood 2 annie Zip Code) 21209 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19a. Informant's Name/Relationship (Type. Print) item 27 is 720 leannetk oppona 'alle other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition (of l Department of Important: If it any Injury or o 1 Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 21. Significe of Funeral Service Licensee Name and Address of Facility MD 2125 alto. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest Immediate Cause (Final **Physician** 1000 disease or condition resulting in death) /Medical Due to (or as a consequence) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑No Month Day Year 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: Yes 2 certificate 1 ☐ Yes 2 No 1 ☐ Yes director, Be 25. Was case referred to medica examiner? 26. Place of Death (Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 → No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After this funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 4 hours at er death Funeral Director 2 Accident by the 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in within 24 hours a To the Funeral C 12 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number June 2, 2009 of death (Item 23a) (Type, Print) 30. Name and address of person who completed cau 57. 31. Date filed (Month, Day, 32. Registrar's Signature State

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Day **Physician** Edna Ruth Redmond 2009 1:35 a^M June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Prince George Laurel Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday, Date of Birth (Month, Day, **Funeral** Months Days 1 ☐ M 2 🔀 F Hours Min 83 Yrs. Director 220-16-4270 Jan.22,1926 VA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Modical Examinar must be nothing at 1 ☐ Yes 2 X No Director MD Howard Savage 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8409 Woodward Street USA 20763 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛱 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 No Completed by If Yes, Give Specify 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Johns Hopkins APL Elementary/Secondary (0-12) College (1-4or 5+) Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Otis Conner 2 Minnie Pierce 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Jane Leishear/ -in-law 8409 Woodward St., Savage, MD 20763 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 4 permit. Pages 1 Department of H Important: If ite any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem.Park Dorsey, MD 4 ☐ Donation 5 ☐ Other (Specify) 2009 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee Ken Stils M01053 313 Talbott Ave., Laurel, MD 20707 23a. P 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastic Carcinoma of Breast years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or denying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 2 No 1 ☐ Yes 2**X X**No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2√ No Medical Certification: To ty⊠npatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Hospital or Attending 1 🔽 Natural 5 Pending 4 hours after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours To the Funeral 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) June 1, 2009 D23181 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R.G. Bhojraj, MD, 704 Gorman Ave., #T4, Laurel, MD 20707 31. Date filed (Month, Day, Year) -32. Petictrar's Signature State park

Registra

Maryland 21215-0036

Baltimore.

Box 68760.

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Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 200^{Year} Month 9:00p Edward Joseph Roeder Jr. June 1 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Carroll Hospice Dove House Westminster Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Months Hours MD 62 216-48-1473 March 14 1947 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Svkesville Carroll 1 □Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 779 Iron Gate Circle 21784 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Yes 2 Yes Give ^{2□No}Vietnam 1 Never Married 2 Married white 1 □Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Atlas Hydrolics Elementary/Secondary (0-12) College (1-4or 5+) owner & operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary T. Staab Edward J. Roeder Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 779 Iron Gate Circle, Sykesville, MD 21784 Beverly Roeder (spouse) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD All County Cremation 6-3-09 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Day Haight Herbert P.O. Box 195 Sykesville, MD 21784 ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Onset and Death MY DER TENSION Due to (or as a consequence of) Due to (or as a consequence of): ves, outcome of pregnancy 23d. Date of delivery 3 Ectopic pregnancy Live birth 2 Fetal death Month

Physician /Medical Examiner

the death certificate be executed

Division of Vital Records, P.O. Box 68760,

or Attending Physician; The law requires that

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Event and the northwant

and burial-trai the attending physician as the use ō page 2 should be detached signed by been this certificate has filled in by the funeral director, After

23a. Part 1. Enter the disease, or complications that sau shock, or heart failure. List only one cause on page Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner by Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Linknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Special Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Cal

. License number

29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

Flavio Kruter

d address of person wh

JUN 0 3 **200**9

29b. Signa

555 S. Center St., Westminster, MD 21157

completed cause of death (Item 23a) (Type, Print)

and manner stated

M.D.,

3. Registrar's Signature Backs

				se Type or Prin					. Ensure A lealth and N				
		•	For State Registrar			-	ertificat				Reg. No.	200	9 17766
			1. Decedent's Name (First, Middle					***************************************		2. Date of De Month	Day	Yea	3. Time of Death
	Physicia /Medic		Emory	н.			Smith		Ir.	June		009 Yea	
e.	Examin	er	4a. Facility Name (If not institution	•					r Location of Death			County of De	
-w'			Gilchrist Cen		- (la .um	land birtheb		OWS r 1 Year	O N If Under 24 Hrs.	8. Date of Bir		altim	Sirthplace (State or Foreign
н	Funeral Director		5. Social Security Number 216-24-6641	6. Sex 1	80	last birthdaj Yrs.	Months	Days	Hours Min.	Fenknyan	av, Year)	.~.	Country) inginia
	pu ,		Usual Residence of Decedent 10a. State 10b. County		100 Cit	y, Town or I	ocation						10d. Inside City Limits
	aryla shov	្ត		:	100. 010	Edgen							1 □Yes 2 No
	28a-1	Director	Maryland Balta 10e. Street and Number	unonce		uiyei	10f. Zi	o Code			10g. Citiz	zen of What (Country?
	with with		7313 Geise Avenu	10				212	719			USA	
	ms 2;	Funeral	11, Marital Status	12. Was Decedent	Ever in U.	S. 13	3. Was Dece		lispanic Origin? (S an, Mexican, Puert	pecify Yes or No		14. Race - Ar	merican Indian,
9	or iter	Ē	1 ☐ Never Married 2 ☐ Marri	Armed Forces?	No		if Yes, spe		Specify:	o Hicari, etc.)	i	Black, Wh	
215-0036	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examirar must be redified at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 🗆 163	Z (2) 140	эреспу.			Specify: W/	
2-0	72 h 'natu	Completed	15. Decedent (Specify only highes	's Education t grade completed)		(Giv	edent's Usu ve kind of wo	ork done	during most of work	king	16b. Kir	nd of Busines	ss/Industry
121	vithin ene. than '	ld m	Elementary/Secondary (0-12)	College (1-4or 5	+)	100	chanic		a)		Rail	road	
d 21	Hygie Hygie ther i	ပိ	6 years 17. Father's Name (First, Middle, I	Last)		1120			18. Mother's Nan	ne (First, Middle			
ano	Mental Mental arked of atic eve	Be c	Emory H. Smith						Lucy Bo	yer			
Maryland	should that and Men smarker umatic	2	19a, Informant's Name/Relationsh			19b. Ma	iling Addres	s (Street	and Number or Ru	ıral Route Numi	per, City o	r Town, State	e, Zip Code)
Ma	1 and 2 s Health a em 27 is		Dorothy Smith	wife		731.	3 Gei	se Az	venue, Ed	gemere,	Mary	land a	21219
ē,	s 1 al		20a. Method of Disposition		20b. F		position (Na rematory or			Date 5,			or Town, State
Ë	Page nent c nt: If iry or		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)				ill Me			009	Влос	klyn,	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyghene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatic event, It a Medical Examiner must be notified at once.		21 Signature of Funeral Service	icensee	00	. (22. Name a	ind Addre	ess of Facility Uneral H	ome Of	Dunda	elk, P. A	4. nyland 21222
	402.00		23a Part 1 Enter the disease of	complications that causes	the deat	h Do not e	7770 S	olle de of dvi	ing, such as cardia	cor respiratory	<i>DUNAG</i> arrest.	ikk, ria	Approximate
			23a. Part 1. Enter the disease, or shock, or heart failure.					200.00	4 (Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	_ a.		13 100	nt o	100	- Wfolm	<u> </u>			weeks
a sangari	Examiner			Due to (or as	a conseq	derice or,							
	, H.	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or as	a conseq	uence of):							
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oʻ	e exe ian ar ırial-t	Ä	resulting in death) Last	Due to (or as	a conseq	uence of):							
9289	ficate be physici s the bu	lical		d									
39	ertific ling p e as t	Physician/Medica	IF FEMALE:	00 - 1/									
Вох	eath certific attending p for use as 1	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 Feta	al death	3 Ectopic		су			23d. Date of Month	delivery Day Year
0	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	at time or o	Jean .	5 ☐ Other (s	specify) _					
σ.	uires that the de signed by the a d be detached f		Part II. Other significant condition	ons contributing to death b	out not res	ulting in the	underlying	cause gi	ven in Part I.	23e. Did	tobacco u	use contribute	e to the cause of death?
Records,	uires sign Id be	d by								1 🗆	Yes 2)	Probably 4 Unknown
00	w requir s been s should	Completed								24a. Wa		24b. Were	e autopsy findings available
Re	he la te has age 2	E E								_ per	opsy formed? 2 2 Ho		to completion of cause of n? Yes 2 □ No
Vital	an: T	Be C	25. Was case referred to medical						26. Place of De	1 □ Yes ath (Check only	_	101	163 2 110
<u>></u>	Physician: The law this certificate has al director, page 2 8		examiner? 1 ☐ Yes 2 ☐No	Hospital: 1 ☐ Inpati	ent 2] ER/Outpa	tient 3 🗆 🛭	OA Ot	her: 4 Nursing h	Home 5 ☐ Re	sidence	6 Cher (5	Specify) hospile
	ding Ph n. After th funeral	Certification: To	27. Manner of Death 1. Natural 5 □ Pendin	28a. Date of Inju	ury ay, Year)	28b. Time Injur		28c. Inju	ury at ork?	28d. Describe	how injur	y occurred	•
Ö		atic	2 ☐ Accident investig	gation			М	1 E	Yes 2□No				
Division	I or Attendi after death. Director: A	tific	3 ☐ Suicide 6 ☐ Could I 4 ☐ Homicide determ		jury - At h tc. <i>(Speci</i>	ome, farm, <i>fy)</i>	street, facto	ry, office			(Street ar own, State		r Rural Route Number,
	urs af rral D	Cel	00.0.0							a and distant	0.000-1) and m	ar as stated
1	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	Medical	29a, Certifier (Check only one) Certifyir (Check only one)	ng Physician: To the best Examiner: On the basis of and manner si	of examin	owledge, de ation and/o	r investigation	on, in my	opinion, death occ	urred at the time	e, date an	d place, and	due to the cause(s)
1	To the within To the comple	Me	29b. Signature and title of certifie	n			2	9c. Licen	ise number		29d. Da	te signed (M	onth, Day, Year)
			Alleran	Const				V	50705		771	re 3	2009
			30. Name and address of person	who completed cause of	death (Ite	m 23a) (Typ	pe, Print)	(1	58303 lines =	STI	יבימול	W M	n
		ate	21. Date filed (Month, Day, Year)	22. Regist	rar's Sign				-3				
	Regist	rar	. HIN 0 3 20	109 Sendia	, 3.	doa	Mad						

			For State	Sta			d / Depa		t of H	ealth a	and Me	ental Hy	giene	3009	177	67
			Registrar 1. Decedent's Name (First, Midd	la Lacti			Ce	runcau	e or L	Jeani		2. Date of De	Reg. No	or. •	3. Time of	Death
4	Physicia	an	Theodore				Save					Month May 27	Da	iy Year 109		5 P ^M
	/Medic Examin	_	4a. Facility Name (If not institution	A. on. give street a	nd number)		Save		Town, or	Location of		nay 27		: County of Deat		<i>J</i> I
-	Examin	EI	Manor Care					Whe	aton				M	ontgome:	rv	
140	Funeral		5. Social Security Number	6. Sex	¬ - 1		ast birthday)			If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da			hplace (State or	r Foreign
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	and **	}	Usual Residence of Decedent 10a. State 10b. Count	· · · · · · · · · · · · · · · · · · ·		10c. City	, Town or Lo	ocation							10d. Inside Cit	y Limits
	Maryli f sho	ō		gomery		Wh	eaton								1XX Yes	2 🗆 No
	28a-	rect	10e. Street and Number	gomery				10f. Zip	Code				10g. Ci	itizen of What Co	ountry?	
	h with	Funeral Director	12519 Bushey D	rive				20	906				U.	S.A.		
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36	or it	y Fu	1 Never Married 2 Ma	rned 1 🖸]Yes 2 ☐ N es. Give	lo		1 ☐ Yes		Specify:			1	Specify:		
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212	3 with jiene. r ther	mo.	Elementary/Secondary (0-12)	Col	lege (1-4or 5	+)	Budg	get Ar	nalys	st			Na	vy		
br	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or itema 23a or 28a-f show aurmatic event, the Madical Examinat must be notified at	Bec	17. Father's Name (First, Middle									(First, Middle		n Sumame)		
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Maryland 21215-0036	2 sho		19a. Informant's Name/Relation											or Town, State, 2	Zip Code)	
	l and fealth im 27		Michael Saveri	no (Ne	phew)	20h P	1					r, PA		ocation - City or	Town State	
or	iges or of or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		I from State	St	lace of Dispo emetery, cre Antho	matory or o	ther plac	e)	6/1/			dber, PA		
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		A .	23a. Part1. Enter the disease, shock, or heart failure. Lis	or complications	that caused	the death								13703	Approximate Interval Bets	9
	Physician		Immediate Cause (Final												Onset and [Death
	/Medical		disease or condition resulting in death)		ectal (Due to (or as a											
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687	ficate p phys is the	edlc		d												
Box 68	n certi	Completed by Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant		es, outcome			Tratagia es						23d. Date of de	,	
B	ne death the atte	sicla	in the past 12 months? 1 \(\subseteq \text{ Yes} 2 \subseteq \text{ No} \)	4	Pregnant at			□Ectopic pr □ Other (sp						Month	Day	r'ear
P.0.	that the de ed by the detached	Phys	9 □ Unknown													
Ś	uires tha signed d be del	by	Part II. Other significant condi Alzheimer's D		ng to death bu	ut not resi	ulting in the u	underlying o	ause givi	en in Part I	l.			use contribute to		
Ö	requi	eted							<u>-</u>							
3ec	e law has t	ldμ										24a. Was auto		prior to death?	utopsy findings completion of c	available ause of
<u>a</u>	n: Th ficate	ပိ	05 Man	-1								1 Yes	2 💢 N		s 2 No	
Ξ	sicial	o Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 ☒ No	Hospita	l: 1 🗆 lapatio	nt 2 🗆	ER/Outpatie	at 2 0	Oth	25:		(Check only		6 ☐Other (Spe	norful	
Division of Vital Records,	g Phy er this	n: To	27. Manner of Death	28a	. Date of Injur (Month, Day		28b. Time o		28c. Injun World	7 42 14		8d. Describe			cuy)	
io	Mtending death. ctor: Aft y the fun	atlo	2 1 700100111	tigation	(MOTHER, Da)	y rear)	Injury	М		Yes 2]No					
i×is	or Attende Director in by th	Certification:	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	not be mined 28e	. Place of Inju	ury - At ho	ome, farm, st	reet, factor	y, office		2	8f. Location (and Number or R te)	ural Route Num	iber,
	ital o irs aft rai Di lled ir	Ser	V													
10	To the Hospital or Attending Physician: The law requires within 24 hours after death. To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be	Medical	29a. Certifier 1 Certify (Check only 2 Medical one)	il Examiner: Or	To the best on the basis of ad manner sta	examina	wledge, dea tion and/or ir	th occurred ovestigation	at the tin	ne, date ar pinion, dea	nd place, a ath occurre	nd due to the id at the time,	cause(date a	s) and manner a nd place, and du	s stated. e to the cause(s	s)
1	within 2 To the	Med	29b. Signature and title of certif		m m	1100.	17	290	c. Licensi	e number			29d. D	ate signed (Mon	th, Day, Year)	
	⊬≰⊨ŏ			0)	()	ارمد	//,		D522	61			Mas	y 27 , 20	09	
			30. Name and address of person	n who complete	ed cause of d	eath (Item	23a) (Type	, Frint)						,,		_
_			Alan R. Segal	, MD			1517 H	lugo C	ir.,	Sil	ver S	pring,	MD	20906		
	Sta		30. Name and address of person Alan R. Segal 31. Date filed (Month, Day, Yea JUN 0 3 2	000	32. Registra	a s Signa	turgant									
All of	Regist	ar	JUN 0 3 2	JUY /CO	-	/	* 8									

		For State Registrar	e Type or Print i n State of Maryla	and / Dep	artmei	e ink. Ensure A nt of Health and I te of Death	Mental Hy		2000	1776				
Physicia /Medic		1. Decedent's Name (First, Middle, James Stephen S	•				2. Date of De Month May	Day	Year 2009	3. Time of Death 2:50 a _N				
Examin	-	4a. Facility Name (If not institution, Sacred Heart Ho	•		1	Town, or Location of Death	n		County of Death					
Funeral Director		344-20-3564	. Sex 10 M 2□F 7. Age (In y	rs. last birthday,	Months	r 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Bir (Month, Da 5/24/1	th y, Year) 927	9. Birth Cou. I111i					
within 72 roots are read with the wayland than "natural", or items 23a or 28a-1 show he Medical Examiner must be notified at	tor	Usual Residence of Decedent 10a. State 10b. County MD Prince	-	City, Town or Lo Iyattsvi				-		10d. Inside City Limit				
23a or 286 st be not	Funeral Director	10e. Street and Number 5805 Queens Cha	pel Road			p Code 0782		10g. Citiz	en of What Cou	ntry?				
al", or items 2 Examiner mu	þ	11. Marital Status 12 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1	n U.S. 13.	Was Decilf Yes, sp	edent of Hispanic Origin? (Secify Cuban, Mexican, Puer 2 No Specify:	pecify Yes or No to Rican, etc.)		4. Race - Ameri Black, White, Specify: Wh					
n "natur Medical E	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		16a. Dece (Give life.	edent's Us e kind of w DO NOT	ual Occupation ork done during most of wo use retired)	rking	16b. Kir	nd of Business/Ir	ndustry				
ntal Hygiene ed other tha event, the I	Be	17. Father's Name (First, Middle, La John Swift	5+	Scho	o1 P	rincipal 18. Mother's Nar France	ne (First, Middle		olic Sch Surname)	ools				
th and Me 77 is mark traumatio	P.	19a. Informant's Name/Relationship				s (Street and Number or Ricson St. Farm	ural Route Numb							
Department of Health and Mental Hygiene. Important: or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 A Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	cify)		ke C	cematory 5/30		Be1t	cation - City or T	MD				
Depar impor any in		1 mgec	1. Signator of Funeral Service Licens MO1539 22. Name and Address of Facility Rapp Funeral 5 Cremation Svcs. 933 Gist Ave. Silver Spring, MD 20910											
hysician /Medical Examiner		23a. Part1. Enter the disease, or c shock, or head failure. List of Immediate Cause (Final disease or condition resulting in death)		kinson'		sease and Den		irrest,		Approximate Interval Between Onset and Death unknown				
ohysician and the burial-transit	dical Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conductor) Due to (or as a conductor)											
y the attending physic ached for use as the b	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal death 3	⊟Ectopic ⊟ Other <i>(:</i>	pregnancy specify)		2	23d. Date of deliv	very Day Year				
n signed by the a uld be detached i		Part II. Other significant condition physical decond	9	•		•			se contribute to □ No 3 □ Pro	the cause of death?				
within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the base.	Completed by	pneumonia	-				24a. Was auto perf 1□ Yes		24b. Were aut prior to c death? 1 ☐ Yes	topsy findings availal ompletion of cause o 2□ No				
s certificate irector, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	2 ☐ ER/Outpatie	ent 3 ☐ E	Othori	ath <i>(Check only</i> Home 5□ Res		S ∏Other (Spec	ni64)				
fn. r. After this e funeral di	tion: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of Injury (Month, Day Yea	28b. Time		28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe			ary)				
to the notation of when the properties of within 24 hours after death. To the Funeral Director. After this certificate his completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could no 4 Homicide determin		At home, farm, st ecify)	treet, facto	ry, office	28f. Location (City or To	(Street and wn, State	d Number or Ru)	ral Route Number,				
within 24 hours To the Funeral completely filled	Medical (Physician: To the best of my kaminer: On the basis of examiner and manner stated.											
withi To th	Ž	29b. Signature and title of certifier	dy		2	9c. License number D43121	29d. Dat	e signed (Manth	n, Day, Year)					
5 /		30. Name and address of person w	ho compared cause of death (ırtonsville,	MD 2086	6		1				
Sta Registr		31. Date filed (Month, Day, Year)	2009 32 Registrar's S	ignatu	arka	1		· · · · ·						

State Registrar

31. Date filed (Month, Day, Year) JUN 0 3 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Schlorff John 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hopkins Baltimore Bayvicw Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 ☐ F Yrs. 458-80-0362 New York Director 20,1951 Usual Residence of Decedent death with the Maryland 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2X No Director Laurel MD Prince George 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20708 U.S.A. 8717 Graystone Lane Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: 2 White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Information Technology Systems Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Russell Edward Schlorff Elizabeth Sharpe ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O Box 462, Thorndale, Texas 76577 Richard Schlorff /brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) June 4, 09 Burtonsville, MD Union Cemetery 22. Name and Address of Facility
Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee 7 M01103 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Deps 1 /Medical (or as a consequence of): Examiner Neurotizina weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner The law requires that the death certificate be executed burial-trar attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy ξ in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 I Inknown 9 Unknown 2 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 2 No 1 ☐ Yes or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1. Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the hours after death uneral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a La Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) completely and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ٥ RES-000 31,2009

State Registrar 31. Date filed (Month, Day, Year)

32. Pegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

Joseph Kelamis

09-04313 Jorge C. Solis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

oorge o. cons		1- For State Registrar	State Of	war yland		tificate of		and Mente		Reg. No.	000 1777
Physici	an/	Decedent's Name (First, I	,						2. Date of De Month		3-/Time of Death
Medical Exami	ner	JORG 4a. Facility Name (if not inst		SOLIS		T ₄	h City Tour	, or Location of I	Month May 30, 2	2009 4c. County of E	1215 hrs
()		3659 Whisky Botto		eet and number)]	Laurel	, or Location or i	Death	Anne Arur	
Funeral		5. Social Security Number	6. Sex	7. Ag	e (In yrs. la	ast birthday)	If Under 1	Year If Under 2	Min	lF	Birthplace (State or oreign
Director		266-98-5687 Usual Residence of Decede		2 F	7	70 Yrs.	Michiero	Suys Hours	June	2, 1938	Country) Chile
any	Ì	10a. State 10b. Col			10c. City,	Town or Location	on			180	10d. Inside City Limits
iand f show	ō		ne Arui	ndel	La	aurel					1 Yes 2XX No
e Mary or 28a-	Director	10e. Street and Number	. D	mara ala D	2		10f. Zip Coo	le 20724		10g. Citizen of What USA	Country?
death with the Maryland or items 23a or 28a-f show must be notified at once.		130 Laure 11. Marital Status		Track R			Decedent of	Hispanic Origin	? (Specify Yes or N		American Indian, Black,
death or iten	Funeral	1 Never Married 2	1		X No	1			uerto Rican, etc.)	White, e	
rs after ural", miner	ā	3 XXWidowed 4 15. Decedent's Education	Divorced of Specify only	Dates:	onleted)			No specify: upation (Give kir	Chilean	Specify: 16b. Kind of Busin	White
72 hou n "nat al Exa	eted	Elementary/Secondary (0		College (1-4 or				life. DO NOT us		Thorough	
0036 within iene.	Completed	12th		Ø		Gro	omer			Horse Ra	cing
21215-0036 und be filed within 7 Mental Hygiene. marked other than e event, the Medica	Be Co	17. Father's Name (First, Mi	ddle, Last)			IIr	nknown	18.Mother's	Name (First, Middle,	Maiden Surname)	Unknown
212 rould b rd Meni is mari	P	19a. Informant's Name/Rela	tionship (Type	, Print)		19b. Mailing	Address (S			imber, City or Town,	
, MD and 2 sho ealth and em 27 is	, di	Gustavo Mag 20a. Method of Disposition	ana/Fr	iend	20h I	406 5			e, Laurel,) 7 ity or Town, State
ages 1 and of the first		1 X Burial 2 Crem	-	Removal from Sta	ate	crematory or oth	er place)		5/9/2009	Laurel,	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	1	4 Donation 5 Other 21. Signature of Funeral Se		- I	1 +	-		ress of Facility			Home, P.A.
			COP	1200K	M011			oott Ave	enue, La	aurel, MD	20707
Physician /Medical		23a. Part I. Enter the diseas	use on each	he.	tne death.	. Do not enter th	e mode or dy	ing, such as car	giac or respiratory a	rest, snock, or neart	Approximate Interval Between Onset and Death
xaminer		Immediate Cause (Final dis or condition resulting in dea		nging to (or as a conse	equence o	f):					
	-a	Sequentially list conditions, if any, leading to immediate	b.	to (or as a conse	equence o	f):					
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nd nd ramsit		events resulting in death) L	ast Due	to (or as a conse	equence o	т):					
760, cate be executed physician and the burial - transit	Medical	UNPENDED	A	MENDED							
8760 ifficate b		IF FEMALE: 23b. Was decedent pregnan		23c. If yes, outcor	ne of preg	,	al death	3 Ectopic r	oregnancy	23d. Date of de Month	elivery Day Year
Box 687 e death certifi the attending	sician	past 12 months? 1 Yes 2 No 9	Linknown	Pregnant at	time of de	oth =	ner (Specify)				.,
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ords, P.O. w requires that the second second by the second	d by								1Y	es 2 V No 3	Probably 4 Unknown
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fital sician: is certil irector	å	25. Was case referred to me examiner?		oital: 1 Inpatie	ent 2	ER/Outpatient		Other	Nursing Home 5	Residence 6 🗸	Other: Scene
of Ving Physical After this uneral dir	ا: ا	1 Yes 2 No 27. Manner of Death		28a. Date of Inju FOUND:	D/	28b. Time of Ir		Injury at Work?		e how injury occurred	
ivision or Attendia after death. Director: A	atio		Pending Investigation	May 30, 2009		FOUND: 1200 hrs	1	Yes 2 🗸 N	10		
Divis	Certification:		Could not be determined	28e. Place of In (Specify) Mu			t, factory, offi	ce building, etc.	or Town,		or Rural Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the contraction of the funeral director.				To the best of m	y knowled	ge, death occur			e, and due to the car	use(s) and manner a	s stated.
Vithin Within M	Medical	one) 2 Medical	an	the basis of examed manner stated.	mination a	nd/or investigati			urred at the time, dat	e and place, and due	
	Σ	29b. Signature and title of co	ertitier	11				ense number .C.M.E.		29d. Date signed May 31, 200	(Month, Day, Year)
	}	30. Name and address of pe	rson who com	pleted cause of d	eath (Item	23a)				, 01, 200	-
		Jack Titus MD.	Deputy Ch	ef Medical E	xaminer	111 Pen	n Street, E	Baltimore, M	D 21201		
St Regis		31. Date filed (Month, Day, Y	ear)	32. Registra	r's Signatu	re la	Med				

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	-	For State Registrar	State of Maryland		artment of H tificate of D			giene Reg. No. 200	9 17771
Physicia /Medic		1. Decedent's Name (First, Middle, Last) STOPHEN		SU	Hes		2. Date of De Month	Day Yes 7 200	9 183/PM
7 Examine	∍r	4a. Facility Name (If not institution, give str The Johns Hopkins Hos 5. Social Security Number 6. Sex	,	st birthday)	4b. City, Town, or Baltimore If Under 1 Year	City	8. Date of Bir	4c. County of D	Birthplace (State or Foreign
Funeral Director			M 2□F 65	Yrs.	Months Days	Hours Min.	(Month, Da 08-07-		Virginia
Maryland ia-f show fied at	ctor	10a. State 10b. County MD Prince Ge		Town or Lo		owie			10d. Inside City Limits 1 ☐ Yes 2 X No
h with the 23a or 28 st be noti	al Director	10e. Street and Number 14502 Dunwood Va1			10f. Zip-Code	721		10g. Citizen of What United S	
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by Funeral		2. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates 1964-68		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 🏋 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	0	merican Indian, hite, etc. White
rithin 72 hours aft ne. nan "natural", or Medical Examir	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	16a. Dece (Give life.	dent's Usual Occupi kind of work done o DO NOT use retired,	during most of work)	ing	16b. Kind of Busine	
and Z1 d be filed wental Hygier ced other the	To Be Cor	17. Father's Name (First, Middle, Last) George Suttles	5+	Comp	iter Prog	18. Mother's Nam	e (First, Middle a Flemi	e, Maiden Surname)	ent
12 mm = 1	۲	19a Informant's Name/Relationship (Type Keum Soo Suttles /	Wife	1450	2 Dunwood	and Number or Rui Valley I	ral Route Numb	oer, City or Town, State	1and 20721
Saltimore, Dermit. Pages 1 as Department of Hee Important: If item any injury or othe		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	Mea	dowri	osition (Name of matory or other place Mem.	Park06-06	Date 5-2009	20c. Location - City Elkridge,	
Departing the popuration of th		21. Signature of Funeral Bervice Licensee	Suarlin		1411 Ann	n Funeral apolis Ro	oad Ode:	& Cremator	ry, P.A. rland 21113
Physician /Medical		23a Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line. Due to (or as a consequence)	Y	er the mode of dyin	ig, such as cardiac	or respiratory a	arrest,	Interval Between Onset and Death
Examiner	Jer	Sequentially list conditions, if any, leading to immediate	OCU+C	M	yeloid	10.01	emi	a	
x 68 / 60, certificate be executed cling physician and use as the burial-transit	al Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):					
x 687 certificate ding phys	ın/Medical	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pregnan			1		23d. Date of	delivery
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	ð	Part II. Other significant conditions cont	ributing to death but not resu	Iting in the	underlying cause gi	ven in Part I.	23e. Did		te to the cause of death? Probably 4 \ Unknown
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AISION OF Attending Physical Actor: After this y the funeral d		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Worl			how injury occurred	
DIVISION all or Attending s after death. al Director: After ed in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At hor building, etc. (Specify)				City or To	wn, State)	or Rural Route Number,
To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	edical	(check only 2 Medical Examin one)	cian: To the best of my know er: On the basis of examinati and manner stated.		vestigation, in my o	ppinion, death occu		e, date and place, and	d due to the cause(s)
To t with	Σ	29b. Signature and title of certifier	orah		29c. License			Juhe Signed (M	1,2009
		30. Name and address of person who co	20 Post Durin Signet	150		600	North W	olfe St, Balti	more, MD, 21287
Sta Registr		31. Date filed (Month, Whear) 3 20	32. Repstrar's Signatu	A .	land of				
DHMH 17 Rev 1/20	001			ORIG	INAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23a per dr., g894,08/18/09/nb

Certificate of Death

Reg, No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 12:02 PM 2009 Richard Lee Sokol las /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSDIAL Baltimore Itimore Baltimore City 0+ uti Birthplace (State or Foreign Country) 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F Months Days Hours Min. 214-56-5019 58 **Director** June 22 1950 Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the hander Examinar must be notified at MD Director Carroll Manchester 1 ☐ Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3041 Michael Dr. Unit 1C 21102 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent ever in 0.3.

Armed Forces?

1 ☑ Yes 2 □ No Vietnam 1 □ Yes 2 ☒ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ð Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) construction carpenter 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Sokol Mary Elizabeth Mingee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Linda L. Sokol (spouse) 3041 Michael Dr. Unit 1C, Manchester, MD 21102 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 6-5-09 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Daige Haright Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Intra Cerebral Hemorrhage **Physician** disease or condition resulting in death) aar /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) that the death certificate be executed physician and s the burlaf-trans Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No detached o 9 I Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, 2 Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed' 2-INo 1 ☐Yes 2 ☐No Vital 1 🗌 Yes After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA o 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attending 1 Natural 5 Pending death. Investigation 1 ☐Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide ō Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) To the I within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/200

State Registrar SYLVANUS

31. Date filed (Month, Day, Year)

JUN 0 3 2009

Known as

SINAI

HOSPITAL

OF

BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OYOGOA, MD

32. Registrar's Signature

Reg. No. 2 3. Time of Death Month Day Year ay 29, 2009 12:37 AMM
Month Day Year
4 V Z J , Z U U J
4c. County of Death
Baltimore
pate of Birth 9. Birthplace (State or Foreig
Month, Day, Year) 5/08/1918 NY
40d Incide City Limits
10d. Inside City Limits 1 ☐ Yes 2 No
10g. Citizen of What Country?
USA
Yes or No- n, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
16b. Kind of Business/Industry
Computer Systems
st, Middle, Maiden Surname)
ltz
ute Number, City or Town, State, Zip Code)
L Air, MD 21014
20c. Location - City or Town, State
y 30 09 Beltsville, Maryland
Alternatives ive Baltimore, Maryland
spiratory arrest, Approximate Interval Between
Onset and Death
etter engl
23d. Date of delivery
Month Day Year
23e. Did tobacco use contribute to the cause of death?
1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknow
24a. Was an 24b. Were autopsy findings available
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24a. Was an autopsy findings available prior to completion of cause of death? 1 □Yes 2□No 1 □Yes 2□No
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24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No eck only one) 5 Residence 6 Other (Specify) Describe how injury occurred
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			4 000	partment of Health and Mental Hygiene ertificate of Death Reg. No. 2009 17774
	Dhysisi		1. Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death
	Physici /Medio	cal	Beulah Marie Woo	May 30, 2009 Year 10:30 P M
6	Examir	ıer	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death
			Manor Care Potomac 5. Social Security Number 6. Sex 7. Age (In vrs. last birthda)	Potomac Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign)
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1	If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. Nov. 3, 1924 North Carolina
			Usual Residence of Decedent	Nov. 3, 1924 North Calolina
	how how		10a. State 10b. County 10c. City, Town or I	ocation 10d. Inside City Limits
-	e Ma 3a-f s riffied	cto	Maryland Montgomery Potomac	1 □Yes 2 汉No
÷	/ith th	Director	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?
=	sath v s 23a nust	era	10714 Potomac Tennis Lane	20854 U.S.A.
Baltimore, Maryland 21215-0036	within /2 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show h. M. Jiral Ev miner must be notified at	by Fu	11. Marital Status 1 □ Never Married 2 ☑ Married 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ☒ No Specify: Specify: White
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121	han."	mpl	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)
2 2	Hygie Hygie ther t	ပိ	12 17. Father's Name (First, Middle, Last)	Buyer Cosmetic 18. Mother's Name (First, Middle, Maiden Surname)
an	ental ental red o c eve	00	Pete Edwards	Arphenie Hensley
ary.	mark mati	၉ .		ling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
S	nd 2% alth a 27 is 27 is			Box 183, Cabin John, MD 20818
re,	permit. Fages I and 2 should be filed within 7.9 Department of Health and Mental Hygiene. Important: if flem 27 is marked other than "in any injury or other traumatic event, it is Medione.		20a. Method of Disposition 20b. Place of Disposition	osition (Name of Date 20c. Location - City or Town, State matory or other place)
E	rage nent c int: if		1 ☐ By fal 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ ponation 5 ☐ Other (Specify) MedCure	June 2, 09 Orlando, FL
i i	porta porta y inju		21. Sign, ture of Funeral Service Licens	22. Name and Address of Facility MedCure
<u> </u>	8 5 E 8 9		Demiller	8018 Sunport Dr. Suite 205, Orlando, FL 32809
	hysician /Medical :xaminer		23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Sequentially list conditions,	Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death
8760, Kate he executed		dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of): d.	tra Healst Failure Jeeding
Division of Vital Records, P.O. Box 6. Hospital or Attending Physician: The law requires that the death certific	by the attending practice as	/Me		□ Ectopic pregnancy
rds, P	n signed t	d by PI	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown
e law re	has been s	nplete	Dem	24a. Was an autopsy findings available prior to completion of cause of
<u> </u>	certificate ha			performed? death? 1 □ Yes 2 ☒ No 1 □ Yes 2 □ No
Vit	certific rector,	00	25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Death (Check only one)
o to	h. After this funeral dir	Ë	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time	(Openin)
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J. Hospit	within 24 hours To the Funera completely fills		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal 2 Medical Examiner: On the basis of examination and/or i and manner stated.	th occurred at the time, date and place, and due to the cause(s) and manner as stated. nvestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
100	within 2 To the completed	ž	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Pay, Year)
			r cun voma	1 10-20114 3/30/07
			30. Name and address of person who completed cause of death (Item 23a) (Type	
	Stat Registra	Ç.	31. Date filed (Month, Day, Year) JUN 0 3 2009 JUN 0 3 2009	1367HESDA, MD 20817

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 13,177 Per fb ment of Health and Mental Hygiene Reg. No. 20 Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Witcher Month Year **Physician** 11:41 PM Marvin 01 lune 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) . Social Security Number Date of Birth (Month, Day, 7. Age (In vrs. last birthday) **Funeral** 212-38-0986 Days Hours 1 XM 2 □ F **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show at Yes 2 ☐ No r 28a-f sh notified Director 10e. Street and Number 10g. Citizen of What Country? ō pe 23a Funeral death v Was Decedent Ever in U.S. Armed Forces?
1 Ves 2 No If Yes, Give Year or Dates: Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Examiner Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced 'natural" Completed 16a. Decedent's Usual Occupation 15. Decedent's Education the Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Department of Health and Mental Hygiene. Important: If item 27 is marked other tran any injury or other traumatic event, the Monce. 18. Mother's Name (First, 17. Father's Name (First, Middle, Last) Be Jora Jackson Edward Menianffee ည 19a. Informant's Name/Relationship (Type. Print) Witchel Kevin 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Penirial Park 6-6-09 Baltimore, Haryland
22. Name and Address of Facility Vaughn C. Greene Funeral Services 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enterone disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory pproximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury) Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 No 26. Place of Death (Check only one) Be Hospital: Other: 1X Inpatient 2 ER/Outpatient 3 DOA 4
Nursing Home 6 Other (Specify) 5 Residence မ 28a. Date of Injury (Month, Day Year) Director: After this d in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending investigation 1 🗌 Yes 2 \square No within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. (check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RES-000 aux Jujoustr June 01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lurowski 600 North Wolfe St, Baltimore, MD, 21287 Jason 31. Date filed (Month, Day, Year) -State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5 M36 - 20 89 7:00 A M **Physician** Wolle Renee /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll New Windsor 1635 Bowersox Rd. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🔀 F 88 219-28-4757 England Director 12-26-1920 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show in than "natural", or items 23a or 28a-f show Westminster Carroll MD 1 ☐ Yes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21157 322 Mary Avenue Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: White Completed by 3 Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Housewife Homemaker other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Wellins Robert Johnson ပ 19a. Informant's Name/Relationship (Type. Print)
Kenneth J. Wolle-son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1635 Bowersox Rd. New Windsor, MD 21776 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ■ Burial 2 □ Cremation 3 □ Removal from State New Cathedral Cem. 6-3-2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home PA 254 E. Main St. Westminster, MD 21157 23a. Part 1 Ender the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 10 Metastatic Breast Cancer yr **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner 88y Advanced Age Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) ☐Yes 2 No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 sl autopsy performed? 1 □ Yes 2 ☑ No 2 No 1 Tes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) son's Other: 4 Nursing Home 55 Residence 6X Other (Specify) residence 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐Yes 2 ☐ No after death Director: / 2 Accident 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Funeral Di 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 6-1-2009 D25443 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3337 Victory Street, Manchester, MD 21102 John W. Middleton 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

09-04280 David Williams

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2009 17777

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ladi		hysici Exami	an/	2 Date of Dooth 3 Time of Dooth
let i	'-dl	Exam		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
				4345 Shamrock Avenue Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign
		uneral irector		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Months Days Hours Min. Hours 1 Months Days Hours Min. Days 1 Q. 1 9. 1 9. Birthplace (State of Foreign Country) 1 Days Hours Days Hours Min. Days 1 Q. 1 9. 1 9. Days Days Days Days Described by Days Days Days Days Days Days Days Day
	pui	28a-f show any	٥٢	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No
	h the Maryla	3a or 28a-f iotified at o	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4345 Shamrock Avenue 2/306 11 Marital Status 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,
	ter death wit	", or items ? er must be 1		11. Marijal Status 1 Never Married 2 Married 2 Married 2 Married 3 Wildowed 4 Divorced If Yes, Give Year 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Yes, specify Cuban, Mexican, Puerto Rican, etc.) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
	MU Z1Z15-UU36 2 should be filed within 72 hours after death with the Maryland	in "natural" cal Examine	leted by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Lor Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
	ວ-ບບວຣ led within ີ	Hygiene.	Completed	17. Eather's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
	Should be fi	of Health and Mental Hygiene. If item 27 is marked other the her traumatic event, the Med	To Be	19a. Informant's Name/Relationship (Type, Print) Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hot 3 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hot 3 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hot 3 19b.
	_ Pu	of Healt of Healt If item		20a. Method of Disposition 20b. Place of Disposition (Name of cemeter) 20b. Place of Disposition (Name of cemeter) 20c. Location - City or Town, State crematory or other place) 20c. Location - City or Town, State
:	Baltimore, permit Pages I a	tar		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Phillip At Weather Fird Funeral Services, P.A. 2431 E.O. Iver St. Balto 2431
1	Phy	/sician Iedical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Also beal and for tarval interval actions.
	æ	aminer		Immediate Cause (Final disease a. ATCONOT and TENTANY INCOMEDIAN Due to (or as a consequence of):
			aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated
	uted	transit	Ιŭ	events resulting in death) Last Due to (or as a consequence or):
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	Records, P.O. Box 68760, The law requires that the death certificate be	the attending physical for use as the bi	sician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)
	. Bo	mat me uear ned by the at detached for	Phys	Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
1	P.O.	signed b	5	Consine use
,	Cords	has been se 2 should	plete	24a. Was an autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
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	Division of Vital Records,	10 the 110spiral or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	Accident 3 Suicide 4 Homicide Fd 5/29/09 Fd 1:\$5 pm 1 Yes 22 No UTIK 28e. Place of Injury - At home, farm, street, factory, office building, etc. townhouse/rowhouse 4 Homicide Fd 5/29/09 Fd 1:\$5 pm 1 Yes 22 No UTIK 28e. Place of Injury - At home, farm, street, factory, office building, etc. townhouse/rowhouse 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4345 Shamrock Ave Baltimore, MD
	Divi	To the inospital of Art within 24 hours after d To the Funeral Direct completely filled in by	Medical Co	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	ئے	3 € 8	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
		D		Carol Hell Ca a O.C.M.E. May 30, 2009
0	D.	end	3 8	30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
		Regis	State	(EDV 1) \$ 700M 7 //-1014 71 700M ACA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Bonnie Yound 2.10 AM 2000 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 312 Highland Drive Apt. Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 □ M 2 🗓 F Yrs Director 215-64-3273 56 06-27-1952 Maryland Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 □Yes 2\No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 312 Highland Drive Apt. T3 Funeral 21061 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filled within 72 hours after of Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Expansion and. 1 □ Never Married 2 □ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: 2 3 Widowed 4 X Divorced Specify: White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Security Guard 12 Spice Plant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Carl Willard Wimmer Etta Jane White 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn V. Dyer / Sister 519 Monterey Ave. Odenton, Maryland 21113 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 DOther (Specify) Arundel Crematory 05-30-2009 Odenton, Maryland . Sig of e uneral Service cense 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebrovascular **Physician** accident disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner pulmonam Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Asmiration resulting in death) Last Due to (or as sconsequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perforr 1 □Yes 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

requires that the death certificate be executed Box 68760 P.O. Records, Division of Vital

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attending phase as the

signed by t I be detach

page 2 should been

funeral director,

filled in

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinat must be notified at

death with the

Baltimore, Maryland 21215-0036

has certificate this After t or Attending s after deau... within 24 hours a To the Funeral D Hospital the

> State Registrar

Macmeka 31. Date filed (Month, Day, Yea

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

2009

Name and address of person who completed cause of death (Item 23a) (Type, Print)
Marmera Xaaillu 1411 Malism Park Drive Suite 16 Hen Bromie MD 21061 32. Fightrar's Signature

Amend #5, per Fh g892 6/15/09 TT / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Lewis Thomas Yeager 31,2009 8:40 Α <u>May</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2011 Oak Lodge Road Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 7 / 20 / 1935 Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Months 1 ₹M 2 □ F 73 Director -32-4705 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the "vectral Examinar must be notified at Director 1 ☐Yes 2X No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2011 Oak Lodge Road 21228 USA within 72 hours after death Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Armed Forces? 1 X Yes 2 □ No Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Investment Banker Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi Jacob T. Yeager Nettie Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a Rose Marie Yeager / Spouse 2011 Oak Lodge Road, Catonsville, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 Date 20c. Location - City or Town, State permit. Pages 1
Department of P
Important: If ite
any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐Donation 5 ☐ Other (Specify) Loudon Park Cemetery 6/4/2009 Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signatur of Funeral Service Licensee 4107 WIlkens Avenue, Baltimore, MD 21229 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on the line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 Z No cate has by page 2 s autopsy performe certificate 1 ☐ Yes 2 Z No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 Residence 6 \subseteq Other (Specify) 1 ☐ Yes 2 ☐ Ño 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After th funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation ours after death.
neral Director: / 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide ö within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29b. Signature and title of certifie death (Item 23a) (Type, Print) Name and address opperso who completed mleu an 01 8 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 23, May Goretha Virginia Brice /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington County Hospital Washington Hagerstown | Hagerscom2 | | House 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov. 18, 1913 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Months 1 □ M 2 🗓 F 232-16-3238 95 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at Director Fulton Warfordsburg 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 4164 Great Cove Road 17267 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Hinkle Grace Shaver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert Scott Sigel/Grandson 376 High Point Cove State College, PA 16801 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 4 Donation Cedar Grove Cemetery 05/27/2009 Warfordsburg, PA 22. Name and Address of Facility 141 West Main Street 21. Signature of Funeral Service Li Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part 1. Enter the disease, or amplibations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ne cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** card /Medical Due to (or as a consequence of) Examiner CINK ana Superitally let our ditions; if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and the burial-trans Due to (or as a consequence of) Physician/Medical yes, outcome of pregnancy ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant

4 ☐ Pregnant at time of death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

VITA

1 Impatient

Date of Injury (Month, Day, Year)

aniel)

32. Registrar's Signature

9 Unknown

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Location (Street and Number or Rural Route Number, City or Town, State) 1 🖵 🗲 crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

2009

Black, White, etc.

White

Specify:

0222 A M

Birthplace (State or Foreign Country)
 WV

10d. Inside City Limits

1 □Yes 2 X No

to the Hospital or Attending Physician: The law requires that the death certificate be execute P.O. Records, certificate Vital Division of

this funeral After Director: hours after within 24 hours after

To the Funeral Dire

completely filled in b within 2 To the F

Completed

Be

Certification: To

Medical

in the past 12 months?

25. Was case referred to medical

2 -No

5 Pending

investigation

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be determined

☐Yes 2 ☐No

20

examiner

1 ☐ Yes

27. Manner of Death

1 Adatural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only

29b. Signature and title of certifier

runcisco

31. Date filed (Month, Day, Year)

0 State Registrar

A5

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

3 Ectopic pregnancy

28c. Injury at Work?

29c. License number 400611

1 □Yes 2 □No

5 ☐ Other (specify)

State of Maryland / Department of Health and Mental Hygiene [] [] 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** $P^{\,\mathsf{M}}$ Raymond Bittinger May 15 2009 5:00 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Dennett Road Manor Nursing Home 0akland Garrett 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2□ F Maryĺand Director 218-01-4284 92 Sept. 1, 1916 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Iteme 23a or 28a-f shov other treumstic event, in Medical Examinar must be notified at 1 Yes 2 No Directo Garrett Mtn. Lake Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 409 L Street 21550 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages t and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If Item 27 is marked other then "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: 3 X Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Contractor Building 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Raymond Edward Bittinger Myrtle Gower 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 Baltimore Ave. Mtn. Lake Park, MD Douglas Bittinger, Son 20a. Method of Disposition
14 Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5/19/2009 6 permil. Page Department of Important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Pleasant Valley Cemetery Oakland, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
David A. Burdock Funeral Home, Katherine Sucitalo 21 N. Second St., Oakland, MD 23a. Part1. Enter the disease, or complications but caused the death. Do not enter the mode of during, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** umer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions. sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence on To the Hospital or Attending Physicien: The law requires that the death certificate be executed burial-transit attending physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed 23e. Did tobacco use contribute to the cause of death? ģ page 2 should be 2 2 No 3 Probably 4 □Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy performed 1 Yes 2 No director, 25. Was case referred to medical 26. Place of Death Check only one examiner' Other: 4 Tursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ 10 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Diractor: After this 28a. Date of Injury (Month, Day Year) 27. Manner eath 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 atural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗋 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral D The certifying Physician: To the best of my knowledge death occurred at the time, date and place, and sue to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Mony), Day, Year) 29c. License number 30. Jame and suress death (Item 23a) (Type, Print) 10 25

Registrar

State

31. Date filed (Month, Day

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parks

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 19 2009 Day **Physician** Eleanor Dorothy Blanchett 2245P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Calvert Memorial Hospital Prince Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month Day Year) May 30 1928 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 □ M 2 □ F New York 056-22-9547 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 10a. State 10h County 'natural', or items 23a or 28a-f show dical Examiner must be notified at Maryland Calvert Port Republic 1 ☐ Yes 2 TNo Director 10g. Citizen of What Country?
United States 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 2, any hijury or other traumatic event, the Medical Examiner must be no once. 5045 Consent Drive 20676 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: white Specify: ρ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Taw legal secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emma Maver Eric Rydberg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheryl Miller - daughter 5045 Consent Dr. Port Republic MD 20676 20b. Place of Disposition (Name of cemetery, crematory or other place) May 20 2009 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Alexandria Virginia Metropolitan Funeral Service 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home 21. Signature of Fune al Service Licensee 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) Physician JUSEN MARY /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, is amy to immodulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Called to Cirica a propagation of the Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician a Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2☐No 1□ Yes 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident I Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 25475 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) dew.5 M. Mathur, MD 110 Hospital Rd. Suite 305 Prince Frederick, MD 20678 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death Year **Physician** 139AM 200 IZET ebecca /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland university 01 Medical Center altmor 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, **Funeral** 1 □ M 2 🗓 F Months Days Hours Min 216-68-0761 Director 53 12-20-1955 Wash., D.C. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any lijury or other traumatic event, If a Medical Example the provided once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Calvert Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19 Well Street 20639 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💥 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No þ If Yes, Give Year or Dates: Specify Specify: 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) school teacher education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Cecil Monroe Bel1 Joyce Virginia Evans 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald K. Byzet, spouse 19 Well Street, Huntingtown, MD 20639 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Central Cemetery 05-22-2009 Barstow, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. Will 8325 Mt. Harmony Lane, Owings, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) Stage **Physician** Ind /Medical Due to (or as a consequence of): **Examiner** Schemiz Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner pital or Attending Physician: The law requires that the death certificate be executed ours after death.
eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: yes, outcome of pregnancy

Live birth 2 Petal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 | Yes 2 | 1 | Yes 1 Monpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital or within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
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State Registrar acen

31. Date filed (Month, Day, Year)

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DO 32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 12:41 A M 2009 Mav 16 Hamilton | Bowen, Jr. William 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert 370 MF Bowen Road Huntingtown 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year) 02-27-1945 If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1 M 2 □ F 219-42-3584 64 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 → No Huntingtown Calvert 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 370 MF Bowen Road 20639 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 📆 Married 1 ☐ Yes 2 🔯 No Specify. 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) commercial heating boiler mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Hamilton Bowen, Sr. Irvine Catterton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 370 MF Bowen Road, Huntingtown, MD Monika M. Bowen, spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 05-19-2009 4 ☐ Donation 5 ☐ Other (Specify) Huntingtown Church Huntingtown, MD 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee 8325 Mt. Harmony Lane, Owings, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BRAIN CANCER GLIUBLASTOMA disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 1 No 1 Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 **N**o 2 ER/Outpatient 3 DOA Injury *Day, Y*ea*r)* 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760. Physician/Medical P.O. I Division of Vital Records, Completed by Medical Certification: To

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The Funeral Director: Af pletely filled in by the fur within 2 To the

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Physician

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Examiner

10a. State

MD

Director

Funeral

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examination in at

Health and Mental Hygiene.

Department of Health a Important: If Item 27 is any Injury or other trauonce.

Physician

/Medical

Examiner

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	Sta

BRUNEY, MD FRANCISCA 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

1 Natural	5 Pending	(Month,
2 Accident	investigation	
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of building,
	/	

Injury - At home, farm, street, factory, office, etc. (Specify)

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number D67814

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2009

995 FREDERICK BLVD N PRINCE 32. Registrarts Signature

FREDERICK PRINCE

20678

Registrar DHMH 17 Rev 1/2001 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Baltimore,	permit. Pages 1 and 2 Department of Health s Important: If item 27 is any injury or other tra once.		21. Signature of Funeral Service Licensee Rathury Surety 7	Name and Addre David A. 710 Chur	ess of Facility Burdock ch Stree	Funeral t, Kitzr	l Hom	e, P.A.	21538			
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	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	ledical C										
	To the within To the comple	Mec	29b. Signature and title of certifier	29c. Licens	se number	- 71	29d. Date	e signed (Moni	th, Day, Year)			
		4	30. Name and address of person who completed cause of death (Item 23a) (Type, Pri	int)	0618	/	1-	7/2/	17			
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Michael Colbert 09-03894

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2009 17788

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		- For State Registrar			Certific	ate of	Death			2	. Date of D	Reg. N	0.	3 Time	of Death
Physicia Medical Examin											Month May 16,	2009		065	5 hrs
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		Prince Georges Hosp	ital Center				Chever	_					Prince Geo	•	2011
Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last bir	thday)	If Under Months	1 Year Days	If Under:	24Hrs. Min.	8. Date of	Birth(M	M/DD/YYYY) 9.	. Birthplace (\$ Country)	State or Foreign
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 Crematic		from State		ntory or oth		mot.	0ry M	fav '	22 2	nnla	Clinto	ın. Ma	rvland
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001		30. Name and address of person					Street,	Raltin	nore M	D 212	01				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Year May 18, **Physician** 6:15 A M Ezekiel Davis, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Burtonsville Sanctuary at Holy Cross If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**X**M 2□ F 238-18-3966 1917 North Carolina Sept 27, 91 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

Em 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Director MD Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20910 1133 East West Highway #825W Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:WWII 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: Black \$ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Mortuary Assistant Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ezekiel Davis, Sr. Mary Fleming 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1133 East West Highway #825W Silver Spring, MD 20910 Mary L. Davis/daughter t: If Item 27 Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important: If Ite
any injury or otl 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State W. Arundel Crematory | 05/19/09 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatus of Funeral Service Licens Going Homes Cramation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** metastati disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dise to for as a consequence of). Examiner law requires that the death certificate be executed use as the burial-trai Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Po Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an certificate has t irector, page 2 s autopsy performed 2 No or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury 28b. Time of 27. Manner of Death 28d, Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 5 ☐ Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

P.O. Box 68760. or Vital Records, Division

Maryland 21215-0036

Baltimore,

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Mont)

Sunitha Beogavilli

29c. License number

D0054566

graj herina Armo #1-17 sil Venspring mn 20902

29d. Date signed (Month, Day, Year)

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Richard Aldo DelRicco 2009 7:15 May 16, A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Memorial Hospital Calvert Prince Frederick Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) **Funeral** Days 1**X** M 2□ F 73 037-22-3745 Director 08-15-1935 Rhode Island Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD 1 ☐Yes 2 🙀 No Calvert Lusby Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12973 Mohawk Drive 20657 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. within 72 hours after 1X1Yes 2 No IfYes, Give Year or Dates: Korea 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White <u>م</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Veterans Administration Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Is marked other than Dental Technician Dentistry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be l and 2 should be fi lealth and Mental H permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked 1 any Injury or other traumatic evolue. Aldo DelRicco Loretta Manfredo 2 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12973 Mohawk Drive, Lusby, Maryland 20657 Cherie DelRicco (Wife) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Highlands 05-20-2009 | Port Republic, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 0. Box 600, Lusby, Maryland 20657 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each live. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical sequence of): Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury Examine death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death signed by the at the detached for 5 ☐ Other (specify) 1□Yes 2□No 9□Unknown 9 🖂 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s performed certificate 2 - NO Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 2 ☐ FR/Outpatient 3 ☐ DOA 1 🗌 Inpatient 2 this funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After Division (Month, Day Year) 1 -Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: / 2' Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ō Hospital 29a. Certifier Certifying Physican: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examin

LRW 6+1

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of pe

29b. Signature and title of certifier

Rafik Nasr, MD 225 Town Square Drive, Suite 2, Lusby, Maryland 20657 32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

MAY 20 2009

29c. License number

D37588

29d. Date signed (Month, Day, Year)

May 19, 2009

		-	For State Registrar	State of Maryla	•		nt of Health a te of Death		Re	g. No.	09	17791
	Physicia		1. Decedent's Name (First, Middle, Last) Charlotte Rable	Esterson					2. Date of Death Month		0 0°9	3. Time of Death 1:35a M
192	/Medic Examin		4a. Fecility Name (If not institution, give s Talbot Hospice	treet and number)			Town, or Location of	of Death		,	ty of Death	1
	Funeral Director			7. Age (In yr. 84	s. last birthday) Yrs.	If Unde Months	or 1 Year If Under Days Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, 1 1 - 20 -	924	Cou	place (State or Foreign ntry) al, France
	Maryland s-f show lited at	tor	Usual Residence of Decedent 10a. State		City, Town or Lo St. Mi		els					10d. Inside City Limits 1 ☐ Yes 2 No
	h with the	Funeral Director	10e. Street and Number 7314 Solitude F	Road			ip Code 21663)g. Citizen o JSA	f What Cou	ntry?
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Heelth and Mental Hygiene. If item 27 is marked other then "netural", or iteme 23a or 28e-f ehow or other traumatic event, the Medical Examinar must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Dec If Yes, sp 1 Yes	edent of Hispanic Or ecrity Cuban, Mexical 2XNo Specify:		ecify Yes or No- Rican, etc.)	ВІ	ace - Ameri lack, White, eify: Wh	etc.
1215-0	within 72 ho ene. then "netur he Mudical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	dent's Us kind of w DO NOT cher	ual Occupation ork done during mos use retired)	st of work	ing	6b. Kind of	Business/ir	
Maryland 21215-0036	should be filed withir and Mental Hygiene. marked other then matic event, the Mental the	To Be Co	12 years 17. Father's Name (First, Middle, Last) Marcelle Rable				18. Moth		e (First, Middle, M			
Mary	nd 2 should bith and Men 27 is marke ir traumatic		19a. Informant's Name/Relationship (Ty) Luc Esterson (s			•	ss (Street and Numb plitude]					
Baltimore,	permit. Pages 1 a Department of Hee Important: If item eny injury or othe once.	ĺ	20a. Method of Disposition 1 ☐ Burial 2 ☐ X remation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		Place of Disponentery, creapitol	matory of				oc. Location	Ť	
Balt	permit. Departr Import. eny tnj		21. Signature of Funeral Service Licensu	I Hales		R.O.	and Address of Facil Carroll I Box 51	Hurl 8, S	ey Fund t.Micha	eral aels,	Home Md	21663
	Physician /Medical		29a, Pard. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Conces	equence of):	He a	ode of dying, such as	lue	or respiratory arre	est,		Approximate Interval Between Onset and Death
,092	ate be executed ysicien and he burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a cons	equence of):	Hyp 165	trectiv	e h	Imene	y &	8.	Lyears Le jears
.O. Box 68	death certifics e attending pt d for use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pred 1 □ Live birth 2 □ F 4 □ Pregnant at time o 9 □ Unknown	etal death 3	□Ectopic □ Other (pregnancy specify)				Date of deliment	very Day Year
<u>α</u>	quires that n signed b uld be deta	ρ	Part II. Other significant conditions con	ntributing to death but not	resulting in the	underlying	cause given in Part	I.		acco use co s 2 □ No		the cause of death?
Vital Records,	: The law requires that the cete has been signed by th page 2 should be detache	Completed	Afr	ral Fik	or-llab	two			24a. Was a autops perform	y ned?	b. Were autoprior to death?	topsy findings available completion of cause of 2 No
Vit	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatie	ent 3□ l	1		th <i>(Check only on</i> ome 5 ☐ Reside		Other (Spec	any) Hospice
Division of		ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time Injury	of M	28c. Injury at Work?		28d. Describe ho			1
Divis	Hospital or Attanding 24 hours after death. Funeral Director: After stely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, s ecify)	treet, fact	ory, office		28f. Location (St City or Town		mber or Ru	ral Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical (sician: To the best of my ner: On the basis of examand manner stated.								
	To the within 2 To the complet	Me	29b. Signature and title of certifier	2. 6-00 01		2	9c. License number					n, Day, Year)
			30. Name and address of person who or	ompleted cause of death //	em 23a) (Tune	Print\	14487	M	D	05	-18	-2009
_	6		Russell Schil	ling.DO 55	5 Cvnw	boo	Dr. Eas	ton,	Md. 2	1601		
	Sta Regist		31. Date filed (Month, Day, Year) NAY 20 20	09 32. Aegistrar's Si	gnature	are						

State

Registrar

MAY 27 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** NOR 2009 /Medical CENTER 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MARYLAND DIGASTIVE PRINCE AUREL GED! LGES DISTASE Birthplace (State or Foreign Country) f Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year, **Funeral** Months Days Hours Min 1 ☐ M 2 🖾 F 85 Staunton, 577-24-8296 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marylanc 10c. City, Town or Location 10d. Inside City Limits 10b. County d other than "natural", or items 23a or 28a-f show event, tre Modical Exp. items to the institution of 1 X Yes 2 □ No Directo Prince George's Maryland New Carrollton 10g. Citizen of What Country? 10e. Street and Number Funeral 6616 Adrian Street 20784 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 ⊠ No If Yes, Give Year or Dates: 1 Never Married 2 Married 0. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: ģ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Kiplinger Editors Machine Operator 7 is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Jeremiah P. Delaney Grace Hoy ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a Janette Taylor / Daughter 6616 Adrian Street, New Carrollton, MD 20784 item 27 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition É Department of Important: If it any Injury or conce. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 5/23/2009 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 4739 Baltimore Avenue 21. Signature of Funeral Service Licensee RAY ROGERS Gasch's Funeral Home, PA Hyattsville, MD 20781 Approximate Interval Between Onset and Death 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. HOLANGIOCARCINOMA Immediate Cause (Final Physician wee disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner EHELME 2 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed g physician and is the burial-trans resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical aftending p use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Year 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has brieficate has brieficate has briefly and control of the control autopsy perform No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner?
172 Yes 2 ☐ No funeral director, Be 26. Place of Death (Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HYSICIAN 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation nours after death.

neral Director: Af 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only one) and manner stated. within 2 29b. Signature and title of dertifier

State Registrar DUSEN

SUITE

NOAD

LAUREL, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1350

VAN

32. Registrar's Signature

KARA

31. Date filed (Month, MAY 2 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2009 3:54 a FOLLETTE JR. 26 May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Hours Days 1 □XM 2 □ F AL 78 Director 410-44-3566 June 6, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, Item of items it aminer must be notified at 1 ☐ Yes 2X No Director Silver Spring MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 72 hours after death with 20906 USA 14124 North Gate Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ☐Yes 2 Yes, Give 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🖾 No þ If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced Black. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within Department of Health and Mental Hygiene, Important: If Item 27 is marked other than any injury or other traumatic event, Item 18 once. Elementary/Secondary (0-12) College (1-4or 5+) Physcian Private Practice 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lysle S. Follette, Sr. Alyce Frazier မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Silver Spring, Md. 20906 14124 North Gate Dr. Denyce Follette - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery June 3, 2009 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD. 21. Signature of Foreral Service Licensex ²² Name and Address of Facility
Marshall s funeral Home of Maryland 4308 Suitland Rd. Suitland, Md. 20746 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Acute Stroke disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Deep Coma Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examiner Hypertension Emergency requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): physician the burial Respiratory Failure Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe he certificate 1 ☐Yes 2 ☐No 1 ☐ Yes 2 🖾 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No After this c မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: or Attending 1 XNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760 P.O. Records, of Vital Division

Baltimore, Maryland 21215-0036

the Funeral Director: npletely filled in by the To the Hospital within 24 hours a To the Funeral D

State

DHMH 17 Rev 1/2001

Registrar

Dr. Majid Rahmanian 31. Date filed (Month, Day, Year)

determined



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

manin

29b. Signature and title of certifier

4 Homicide

(Check only one)

29a. Certifier

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D66372

29d. Date signed (Month, Day, Year)

5/26/2009

Silver Spring, MD. 20910

			for State	S	tate of Ma	aryland /		artment of F tificate of l				_	2000	1770	
			Registrar 1. Decedent's Name (First	, Middle, Last)			Cer	uncate or t	Jeani		2. Date of De	Reg. No. ath	2003	3. Time of Death	J
	Physici /Medio		Corey				Gil	ger			Month	Day	200 9	1821 P	Λ
	Examin		4a. Facility Name (If Not in					4b. City, Town, or			1	4c. (County of Death		
	Funeral	24	The Johns Hop 5. Social Security Number	6. Sex	7. Age	e (In yrs. last t	oirthday)	Baltimore If Under 1 Year	If Unde		3. Date of Bir	th Vacat	9. Birth	place (State or Foreig	ın
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	e Mary 8a-f sh ified a	Director	MD Ca	lvert		Owin	ngs							1 Yes 2 X	0
	h with th 23a or 2 st be not	al Dire	10e. Street and Number 9184 Paulyn	Drive				10f. Zip-Code 20736					en of What Coul	ntry?	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 X Never Married 2 3 ☐ Widowed 4 ☐ D	☐ Married 1	Vas Decedent E Armed Forces? Yes 2 X N Yes, Give Year or Dates:	ver in U.S. No		Was Decedent of H f Yes, specify Cuba □ Yes 2 X No	lispanic Or an, Mexica Specify		ify Yes or No can, etc.)		4. Race - Americ Black, White, Specify: Wh	etc.	
21215-0036	72 hou 'nature dical E	Completed		ecedent's Education y highest grade cor		16	(Give	lent's Usual Occup	during mo	st of working	9	16b. Kir	nd of Business/Ir	ndustry	
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pu	al Hygi I other vent, t	Be C	17. Father's Name (First, M			,					(First, Middle	, Maiden	Surname)		
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Baltimore,	es 1 au of Hea fitem ir othe		20a, Method of Disposition 1 Burial 2 Crer	nation 3 Remo	val from State	20b. Place ceme	of Dispo	sition (Name of natory or other place	ce)	May 200	^{te} 23.	20c. Loc	cation - City or To	own, State	
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Ba	Depa Impo any is once	ls s	SOFM	// Joh	MO1464 in F. Ho	olmes	81	25 South	ern M	Maryla	nd Br	7d. U	me Calv wings,	ert, P.A. MD 20736	
			23a, Fart 1. Enter the dise shock, or heart failur mmediate Cause (Final	e. List only one car	use on each line	9.					respiratory a	ırrest,		Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	a	Due to (or as a	Venc a consequence	e of):	clusive	dise	ease					
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8760,	ificate be executed g physician and as the burial-transit	edical													
9	curtifica ding ph	η/Me	IF FEMALE:	23c. If	yes, outcome	of pregnancy							3d. Date of deliv	one	
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	signe ld be	by	Part II. Other significant of	conditions contribu	iting to death bu	ut not resultin	g in the u	nderlying cause gi	iven in Par	t I.	23e. Did 1		se contribute to	the cause of death?	n
Division of Vital Records,	The law requate has been page 2 shou	Completed									24a. Was autoj perfo Yes			opsy findings availab ompletion of cause o	
Ĭ Ž	sician: Th certificate lirector, pa	Be c	25. Was case referred to rexaminer? 1 Yes 2 No	nedical Hospi	ital: 1 Inpatier	nt 2 🗆 ER/0	Outnatient	t 3 □ DOA Oth	or.	,	Check only o		 □ Other (Specia		_
n of	g Physer this neral d	on: To	27. Manner of Death	Pending 28	Ba. Date of Injury (Month, Day)	y 28t	o. Time of Injury		y at		d. Describe			77	_
Sio	tendin leath. or: Aft the fu	catic		investigation		_			Yes 2		of Landina	Chro and a ma	d Montes es Deu	al Doute Number	_
<u>≥</u>	after of Direct	Certification:	4 Homicide	determined	building, etc.		iaiii, siie	et, lactory, office		20	City or Tov		i Number or Aur	al Route Number,	
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical C		ertifying Physician ledical Examiner:		examination a									
	To the within 2 To the comple	Med	29b. Signature and title of					29c. License	e number			29d. Date	signed (Month,	Day, Year)	
			1 Ch	Litte	WATSON	an,		RES	5-00	00		Ma	iy 16,	2009	
اد	w .5		30. Name and address of	erson who comple	eted cause of de	eath (Item 23	a) (Type,	Print)		600 N	orth Wa	lfe St	. Baltimo	re, MD, 2128	37
	Sta		31. Date filed (Month, Day,		32. Registra	s Signature	ß	1	>	230 11			, – 3111110		
	Registr	ar		MAYZUZ	ΨU9 > <i>L</i> &	news	1.	Sparked					•		

09-04122 John E. Glanden

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 17796

		1- For State Registrar	Certificate of	Death	F	Reg. No.	
Physici		Decedent's Name (First, Middle,Last)			Date of Dea Month	Day Year	3. Time of Death 1955 hrs
edical Exami	iner	John Eric Glanden		4b. City, Town, or Locat	May 23, 2	2009 4c. County of Death	
		4a. Facility Name (if pot institution, give street and num 1396 Market Street 1396 Market Street	Neck Road	Denton Bish		Worcester	
Funeral		5. Social Security Number 6. Sex 7	. Age (In yrs. last birthday)			irth(MM/DD/YYYY) 9. Bir Foreig	thplace (State or
Director		215-96-6334 1xm 2_F	42 Yrs		Hours Min. January	27, 1967 Co	^{untry)} Maryland
y		Usual Residence of Decedent 10a. State 10b. County	10c. City. Town or Locat	100			10d. Inside City Limits
ow an			_	1011			1 Yes 2 No
Maryland 28a-f show any d <u>at once,</u>	햟	Maryland Caroline 10e. Street and Number	Denton	10f. Zip Code		10g. Citizen of What Cou	
ne Mai or 28	Director	1348 Market Street		21629		United State	es of America
5 72 hours after death with the Maryland n "matural", or items 23a or 28a-f she sal Examiner must be notified at once			dent Ever in U.S. 13. Wa	as Decedent of Hispanic	c Origin? (Specify Yes or N	lo- 14. Race - Amer	ican Indian, Black,
leath r item	Funeral	1 Never Married 2 Married Armed For	ces? If Y	es, specify Cuban, Mex	xican, Puerto Rican, etc.)	White, etc.	
after o al", o	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1	Yes 2 X No spe		Specify: Cauc	
hours	ed L	15. Decedent's Education (Specify only highest grade	during m	nt's Usual Occupation (6 nost of working life. DO I		16b. Kind of Business/	Industry
36 in 72 han "	plet	Elementary/Secondary (0-12) College (1-12 HS Grad	' I	Contractor-	self Employe	d Constru	iction
-00; d with giene ther t	Completed	17. Father's Name (First, Middle, Last)			other's Name (First, Middle		3002011
215 be file stal Hy ked o	Be	Lee John Glander			Joann Murphy		
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Montal Hygiene. The is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	ုင	19a. Informant's Name/Relationship (Type, Print)			Number or Rural Route No		
MD id 2 sh ilth an m 27 i					eet, Denton,	Maryland 21	
imore, MI Pages I and 2. nent of Health 8 ant: If item 27 or other traum		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal fro		sition (Name of cemeter ther place)	"	,	
Page ment tant:		4 Donation 5 Other Specify:		it Cemetery		Hillsboro	
Baltimore, permit. Pages I an Department of Hee Important: If ite injury or other tr.		21. Sign ure of Funeral Service Licensee	22. I Mc	Name and Address of Fa Pore Funera	acility 1 Home, P.A. ond Street,	Donton Mary	vland 21629
Physician	_	23a. Part I. Enter the disease, or complications that ca	used the death. Do not enter	South Sectine mode of dying, such	ond Street, as cardiac or respiratory a	rrest, shock, or heart	Approximate Interval
/Medical	6 U	failure. List only de cause on each line.					Between Onset and Death
xaminer	ı		consequence of):				
	L	Sequentially list conditions, b					
	je.	cause. Enter Underlying Cause	consequence of):	=41			
sit od	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a	consequence of):				
760, icate be executed sphysician and the burial - transit	<u>ہ</u>	UNPENDED TO AMENDED	4a,4b, & 28f,	perME g892	2 6/3/09 TT	-	
760, icate be exemply sician a physician at the burial -	/Medical		utcome of pregnancy			23d. Date of delive	ry
68760, certificate be nding physic se as the bur		23b. Was decedent pregnant in the	rth 2 Fe	etal death 3 E	Ectopic pregnancy	Month	Day Year
Box 687 death certifine the attending of for use as t	Physician	1 Yes 2 No 9 Unknown 9 Unknown		ther (Specify)			
y the do	P _y	Part II. Other significant conditions contributing to		underlying cause given	in Part I. 23e. Did	tobacco use contribute to	o the cause of death?
P.O es that to igned b	d b				1Y	res 2 No 3 Pro	obably 4 🗹 Unknown
Records, The law requir ficate has been s	Completed				24a. Wa		utopsy findings available completion of cause of
eco ne law te has	E G				per	formed? death?	
LL '	C C	25. Was case referred to medical			Death (Check only one)		
of Vital ig Physician: After this certi	TO B	examiner? 1 Ves 2 No Hospital: 1 I	npatient 2 ER/Outpatien	t 3 DOA Othe	er Nursing Home 5	Residence 6 🗸 Other	er: Scene
	=	27. Manner of Death 1 Natural 5 Pending FOUND	of Injury Day,Year) 28b. Time of FOUND:		Subject m	be how injury occurred totorcyclist involved	in motor vehicle
tend tend death. ctor: y the f	iệ	1 Natural 5 Pending FOUND: 2 Accident Investigation May 23,	2009 1939 hrs	1_ Yes	accident		15 1 11 11 11 11
Division Division pital or Attendi ours after death. crat Director: /	Certification:	3 Suicide 6 Could not be determined (Specify)	of Injury - At home, farm, stre		ing, etc. 28f. Location or Town	n (Street and Number of B n, State) 12900 B1	
Division Bospital or Attent A hours after death Funeral Director: tely filled in by the		29d. Certifier 4 Continue Bhusinian. To the hor	Major Road / Highwa	y	BIShor	osville, MD	Neck Rd.
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	one) 2 Medical Examiner: On the basis of	f examination and/or investiga	ation, in my opinion, dea	ath occurred at the time, da	ite and place, and due to	the cause(s)
To To Com	Mec	29b. Signature and title of certifier	ated.	29c. License nu		29d. Date signed (M	onth, Day, Year)
		110 111	alto x	O.C.M.E	e. OCME	May 25, 2009	
		30. Name and address of person who completed caus	e of death (Item 23a)) ; ; ;			
			nt Medical Examiner		t, Baltimore, MD 212	01	
S	tate	31. Date filed (Month, Day, Year) 32. Re	strar's Signature	bartes			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10e, ft. 19b Per FH G892 6/18/09 JH. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Year **Physician** May 22, 3:00 P M Reba Maxine Hill /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death **Examiner** Golden Living Center Washington Hagerstown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year)
April 2,1914 7. Age (In vrs. last birthday **Funeral** Days 1 □ M 2 🕅 F 95 220-46-7706 PA Director Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show adral Examiner must be notified at 1 ☐ Yes 2√√No Director Frederick MD Middletown 10e. Street and Number 6727 Deer Spring Lane 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with 21769 6727 Deerspring Lane 21781 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: White Specify 3 ☑ Widowed 4 ☐ Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Nurse Health Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willard Palmer Belva Akers 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6727 Beerspring Lane Middletown, MD 21781 19a. Informant's Name/Relationship (Type. Print) Wanda L. Zink/Daughter 6727 permit. Pages 1 a Department of Hea 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Important: if It any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State Rehobeth U.M.Cemetery 05/27/2009 Mercersburg, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest 10 Immediate Cause (Final **Physician** dai resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Unweitying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit 6 and Due to (or as a consequence of) Box 68760 attending physician Physician/Medical for use as the IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) P.O. the detached 2 - No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 ☐Unknown 1 TYes Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform page certificate 2 🗆 No Division or Vital 1 Yes 2 1 No 1 TYes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 ☐ Yes 2 ☐ No 1 🔲 Inpatient 2 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: or Attending 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check on one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. and title of certifier 29b. Signatur 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIDORA

32. Registrar's Signature

7

Year!

31. Date filed (Month, Day,

Reg. No.	4	U	U	3	I	1	1	J	(
rrygiene	0	\cap	\cap	0	1	-7	7	\cap	0

Physicia /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Evaninar must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

State Registrar

	1 - State Registrar			Ce	rtifica	te of L	Death			Reg. N	10. <u>C</u>	JUS)	190
	1. Decedent's Name (First, Middle, Last	<u>'</u>)							2. Date of Dea	ath			3. Time o	of Death
•	Chery11	Ann			На	ardy			Month 5	14	ay 1	Ye ar 2009	6:50	Ам
	4a. Facility Name (If not institution, give						Location	of Death			c. County			
•			,									omio		
	1101 Hillcrest Av 5. Social Security Number 6. Se		Age (In yrs.	last hirthday	+	Salis er1Year	If Under	24 Hrs.	8. Date of Birt	L			hplace (State	or Foreian
į			. Age (m yrs.	52 Yrs.	Months		Hours	Min.	(Month, Da	y, Year		Co.	untry)	or i or orgin
	Usual Residence of Decedent			32					7-18-	195	0	Ma.	ryland	
	10a. State 10b. County		10c. Cit	ty, Town or L	ocation								10d. Inside (City Limits
5													1 □Ye	s 2X No
Directo	MD Wicomic	0	S	alisbu		0.1.				10- 0	Distance of t	Mhat Ca	Out of the contract of the con	
5	10e. Street and Number				101. 21	p Code				rog. c	Citizen of	vviiai Co	unity:	
g	1101 Hillcrest Ave	nue					1804				U	SA		
aur	11. Marital Status	12. Was Deced	ent Ever in U. es?	.S. 13.	Was Dece	edent of H	lispanic Or an, Mexicai	igin? (Spe	cify Yes or No Rican, etc.)	-		ce - Ame ck, White	rican Indian, . etc.	
	1 ☐ Never Married 2 ☐ Married	Armed Forc 1 Tes 2 If Yes, Give	X No		1 □Yes		Specify:					v: Wh		
completed by Funeral	3 ☐ Widowed 4 X Divorced	Year or Dat									Opcon	y. **11		
ere	15. Decedent's Edu (Specify only highest grad	ication le completed)		16a. Dece	edent's Usu e kind of w	ual Occup	ation during mos	at of workin	na	16b.	Kind of B	usiness/	Industry	
ğ	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT L	use retired	1)					~		
Į.		2		Bus I)rive	r				Wl	comi	co Co	ounty	
ag	17. Father's Name (First, Middle, Last)						18. Moth	er's Name	(First, Middle,	Maide	en Surnar	ne)		
0	Roy Earl		На	rdy II			Doris	s Lou	ise			Vaus	ghan	
	19a. Informant's Name/Relationship (7)	vpe. Print)				s (Street			l Route Numb	er, City	or Town			
	Kelly Driscoll - D	aughter		731 E	i chw	11 г	rivo	Sa1	isbury	M	22571	and '	2180/	
	20a. Method of Disposition	augneer	20b. F	Place of Disp cemetery, cre					ate				Town, State	
	1 ☐ Burial 2 🕅 Cremation 3 🗆 I		ate				1			_		_		
	4 ☐ Donation 5 ☐ Other (Specify,		Cre	mator	<u></u>								laware	
	21. Signature of Funeral Service Licens		a ()		2. Name a			ЪО	unds Fu					
		ely Gar							Salisb		, Ma	ry1ą		
	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o	lications that cau	sed the deat	h. Do not er	nter the mo	de of dyin	ng, such as	cardiac o	r respiratory a	rrest,			Approxima Interval B	etween
	Immediate Cause (Final disease or condition	Nov	Smal	CEN	Ly		Can						Onset and	Death
	resulting in death)	a. Due to (or	as a conseq	uence of):	(-)	OCTAI	C-01						
		,		,	`									
<u>5</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or	as a conseq	uence of):										
	cause. Enter Underlying Cause (Disease or injury													
Examine	that initiated events resulting in death) Last	C. Due to (or	as a conseq	uence of):										
Medical		a												
Ž	IF FEMALE:	23c. If yes, outco	me of prean	ancv							034 D	ate of del	livory	
a	23b. Was decedent pregnant in the past 12 months?	1 Live bir	th 2 Feta	death 3	Ectopic		У					onth	Day	Ye ar
Sicia	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknov		Jean 5	Other (s	speciiy)								
Ē	Part II. Other significant conditions co	ntributing to do-	th but not so-	ulting in the :	ındorlyin -	cause at	on in Dord	I	230 Did+	ohace	n use con	tribute *	the cause o	f death?
2	art II. Other significant conditions co	an builty to dea	a Dut HOLIES	arang in the t	andenying	cause givi	en in Fall							,
completed by									10	162	2 No	3 □ Pi	Obably 41	Unknown
로									24a. Was		24b.	Were au	utopsy finding completion of	s available
<u> </u>									perfo	rmed?		death?	`	
וע	25. Was case referred to medical						26. Plan	e of Death	(Check only o			, 103		
ם כ	examiner?	Hospital:	patient 2 🗆	FB/Outpatie	ent 3 🗆 D	OA Oth	05:		ne 5 R Resi		6 □0+	her /Sno	ocify)	
-	27. Manner of Death	28a. Date of	Injury	28b. Time		28c. Injur Work			28d. Describe			1-1-		
CallO	1 Natural 5 ☐ Pending investigation	(Month,	Day, Year)	Injury	М		k? Yes 2□	INo						
2	3 ☐ Suicide 6 ☐ Could not be	28e. Place o	f Injury - At he	ome farm st	reet factor				28f. Location (Street	and Num	ber or Ri	ural Route Nu	ımber.
	4 Homicide determined	building	, etc. (Speci	fy)		,,,			City or To	wn, Sta	ate)	20, 0, , ,		
	29a. Certifier 1 Certifying Phy	reician: To the h	get of my kno	wledge des	th occurre	d at the tir	me date a	nd place	and due to the	Called	(e) and n	nannar a	e etated	
2	(Check only one) 2 Medical Exam	iner: On the bas	is of examina											e(s)
Medical	29b. Signature and title of certifier	and manne	stated.		20	9c. Licens	e number			294 [Date einh	ed (Mont	th, Day, Year)	
-	200. Signature of tertiller							9		-	THE	() G	, = 0, 1001/	
						000	6198	3		J	1171	V		
	30. Name and address of person who c	ompleted cause	of death (Iter				, .		(-	1 11		,	
	Justinian Nagiza	a mb a	LD 12	DO EC	9,00	1 36	<u> 5</u>	9/13/	oury	MI) 2	190		
	31. Date filed (Month, Day, Year)	1000 32/ R	gistrar's Signa	ature	back	1	- 1) 1	-				
	MVI T 9 7	VUD /		1. 1		W								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-04020 State of Maryland / Department of Health and Mental Hygiene 2009 17799 Gilbert Earl Harvey 1- For State Certificate of Death Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day May 20, 2009 1345 hrs Medical Examiner Gilbert Earl Harvey 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Garrett Oakland Route 219 West and Sand Flat Road 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex **Funeral** Foreign Months Days Hours Country) Director Maryland Vrs 09/18/1911 1 XM 2 F 218-16-2851 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 'n 1 Yes 2 X No 0akland MD Garrett after death with the Maryland Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number United States 21550 136 Paradise Point Rd. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Drigin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 2 X No Ves ō Yes 2 X No specify: Specify: White Divorced f Yes. Give Year Widowed 4 altimore, MD 21215-0036
mit. Pages I and 2 should be filed within 72 hours after partment of I leath and Mental Hygiene.
portant: If item 27 is marked other than "natural", ury or other traumatic event, the Medical Examiner. ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Farming Farmer 10 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Ann Rodehaver Be Harvey Sidney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 136 Paradise Point Rd., Oakland, MD Randy Harvey, Cousin 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a, Method of Disposition Baltimore, 05/23/2009 crematory or other place) Removal from State 1 X Burial 2 Cremation 3 Oakland, MD Garrett Memorial Gardens Donation 5 Other Specify: 22. Name and Address of Facility David A. Burdock Funeral Home, P. 21. Signature of Funeral Service Licensee 2nd St., Oakland, MD 21550 21 N. Ratherine Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line Death "Medica a. Multiple Injuries Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examiner cause. Enter Underlying Cause Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical **AMENDED** UNPENDED attending physician for use as the burial Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Dav Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Fetal death Live birth 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown certificate has been signed by the ector, page 2 should be detached it 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Yes 2 ✔ No 3 Probably 4 Unknown þ Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? 2 1 🗸 Yes No ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: within 24 hours after death
To the Funeral Director: After this certifi completely filled in by the funeral director, Be Hospital: 1 Other, Residence 6 V Other: Scene examiner? Nursing Home 5 DOA Inpatient 2 ER/Outpatient 3 ٩ 1 🗸 Yes 2 No 28c. Injury at Work? 28d Describe how injury occurred 28a. Date of Injury (Month, Day Year) May 20, 2009 28b. Time of Injury 27. Manner of Death Driver auto auto collision Certification: Yes 2 V No Natural Pending 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be or Town, State)
Route 219 West and Sand Flat Road, Oakland, MD Suicide determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Chack only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 21, 2009 O.C.M.E.

Registrar

Ø

State

Ana Rubio MD.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32, Registrar's Signature

anto

111 Penn Street, Baltimore, MD 21201

dcian _..ledical Examiner Medical Examiner

Physician

/Medical

Examiner

Funeral Director

Be Completed by

၉

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at

Baltimore, Maryland 21215-0036

use as the burial-transi

b Hospital or Attending Physiclan: The law requires that the death certificate be executed 24 hours after death.
b Funeral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, o the within 2 To the

Division of Vital Records, P.O. Box 68760,

Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
ρ	Part II. Other significant conditions of	contributing to death but not resulting in the	underlying cause given in Part I.		use contribute to the cause of death? ☑ No 3 ☐ Probably 4 ☐ Unknow
Completed				24a. Was an autopsy performed? 1 □ Yes 2 □ No	24b. Were autopsy findings availabl prior to completion of cause of death? 1 □ Yes 2 □ No
Be	25. Was case referred to medical		26. Place of De	ath (Check only one)	
은	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat	tient 3 DOA Other: 4 Nursing H	Home 5 ☐ Residence	6 ☐ Other (Specify)
	27. Mannef of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time Injury	of 28c. Injury at	28d. Describe how injur	ry occurred
Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		street, factory, office	28f. Location (Street as City or Town, State	nd Number or Rural Route Number, a)
Medical (nysician: To the best of my knowledge, de miner: On the basis of examination and/or and manner stated.			
ME	29b. Signature and title of certifier		29c. License number	29d. Da	ite signed (Month, Day, Year)

D-25914

MAY 19, 2008

RIVER DALE, MARYLAND

State Registrar BRIMMER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

4409 EAST- WEST HIGHWAY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 0345M 10 ames 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** albo Hospital at Easton Easton morial If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, **Funeral** Days Year) Hours 216-54-7709 02/24/1950 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. ant of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Worton Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Hackett 2167 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Blac 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Chrysler Motors College (1-4or 5+) th neworker 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Starling Hackett Mar ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Department of Health a Important: If Item 27 Is any injury or other trauonice. 11316 Hackett Rd. Worton, MD entina Hackett 20b. Place of Disposition (Name of cemetery, crematory or other place)

NEW Christian Chapel

of Love Cemetery

22. Name and Address of Fig. 20c. Location - City or Town, State Date 20a. Method of Disposition Chestertown, MD Burial 2 Cremation 3 ☐ Removal from State 16/09 4 Donation S☐ Other (Specify) Service Licensee Bennie Smith Funeral Home of Funer Chestertown, HD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Physician Myclogenous Leutenia MOS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Due to (or as a consequence of): 43 Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 TYes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has t certificate ha Yes director. 25. Was case referred to medical 26. Place of Death (Check only one To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this After th funeral 27. Manner of Death
1 Natural
2 Accident 28c. Injury at Work? Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A completely filled in by the f 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ek2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RX 3

Registrar

State

31. Date filed (Month, Day,

Year

MAY 19

State of Maryland / Department of Health and Mental Hygiene [] [] 9 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** ROBERT ERNEST JOHNSON MAY 28 2009 10:10AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 10200 LA PLATA ROAD LA PLATA CHARLES If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** XXM 2 F Director 249-38-3445 AUG. 2, 1926 SO.CAROLINA Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 27 is marked other than "natural", or Itama 23a or 28a-f show traumatic event, the Madical Examinar must be notified at XX es 2 □ No Director MD CHARLES LA PLATA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10200 LA PLATA ROAD 20646 S. A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 245 No II Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: WHITE Specify: 3 ₩ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) AUTO MECHANIC AUTOMOTIVE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ROBERT JOHNSON MAY DAVIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEPHEN R. JOHNSON/SON P.O.BOX 626 BRANDYWINE, MARYLAND 20613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition MAY Department of Important: If it any Injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 30,2009 ALEXANDRIA, VA METRO. CREMATORY 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 21. Signature of Funeral Service Licensee M00641 5635 WASHINGTON AVE., LA PLATA, MD20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ailuse **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Poor Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit Kecent Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 10 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 TER/Outpatient 3 TDOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: Manner of Death 28b. Time of 28d. Describe how injury occurred the Hospital or Attending Natural 5 Pending 1 Yes 2 No death. investigation 2 Accident Director 6 Could not be determined 3 T Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 [] Homicide 29a. Certifier 1 🔾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. th. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 5/29/00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Sfe 103; Waldorf, MD 20602. arinala, MD. 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 02:03 AM 16 2009 May Donald Arthur Joseph 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Cecil 68 Duck Hollow Drive If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Months Days Hours July 22,1924 296-14-0356 84 Ohio Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County 1 ☐Yes 2 XNo Cecil E1kton Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21921 United States 68 Duck Hollow Drive 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2XXMarried 1 N Yes 2 □ No If Yes, Give US Navy Year or Dates: 1 ☐ Yes 2 💢 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Precious Metals 12 4 Vice President and Treasurer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Grolle Arthur Joseph 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 68 Duck Hollow Drive, Elkton, Maryland Carolyn Joseph / Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition May 22. 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Newark, Delaware Mayerdale Crematory 21. Signature of Farer & Service Licent 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Physician /Medical **Examiner**

and

Physician

/Medical

Examiner

Director

Funeral

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Be Completed

Funeral

Director

Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

be filed within 72 hours after

Pages 1 and 2 should

if Health

Baltimore, Maryland 21215-0036

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burial-transit the nse signed by t page 24 hours after death.
Funeral Director: After thi etely filled in by the funeral

The law requires that the death certificate be executed

Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760,

	disease or condition	a Lung (ancer		ununoun
	resulting in death)	Due to (or as a conhequence of):		
iner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of):	- 1	
cal Exam	Cause (Disease or injury that initiated events resulting in death) Last	c		_
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 9 Unknown	23d. Date of de Month	livery Day Year
ed by Pr	Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	o the cause of death? robably 4 □Unknown
Complete			autopsy prior to performed? death?	utopsy findings available completion of cause of
Be (25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
일	1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	e 5 Residence 6 □Other (Spe	ecify)
ation:	27. Manner of Death 1 X Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year) Injury Work? M 1 ☐ Yes 2 ☐ No	d. Describe how injury occurred	
ertifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	f. Location (Street and Number or R City or Town, State)	lural Route Number,
ledical Certification:		ysician: To the best of my knowledge, death occurred at the time, date and place, an niner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.		
e			2015 1 1 1 1 1	. 51 1/ 1

To the

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State

Registrar

001 31. Date filed (Month, Day, Year)

MAY 19 2009

me and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician ELIZABETH JAMISON 2:00 PM 2009 MAY 18 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death COPPER RIDGE Carroll Sykesville 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 M 2000 F Director 82 Delaware 222-70-3683 Aug 10, 1926 Wilm, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 1 ☐ Yes 2 ☐ No Funeral Director DE New Castle Centreville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code is 1 and 2 should be filed within 72 hours after death with of Health and Mental Hygiene. It is a 72 is marked other than "natural", or items 23a or other traumatic event, the Medical Exampler must be cother traumatic event, the Medical Exampler must be 19807 101 Havernill Lane USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 💢 No Specify: Completed by 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental I Clement Acton Lippincott Elizabeth Buckley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa J. Hansen 2257 Hickory Hill Rd. Chadds Ford, PA Date 20c. Location - City or Town, State 20a. Method of Disposition 28b Place of Disposition (Name of S Coemako, Sapariory Of bthur Bace) permit. Pages 1
Department of P
Important: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Burial / Brandywine Memore Programme and Programme and Programme and Programme Burial Programme Programme Burial Programme Programme Burial Pr May 22 2009 4 Donation 5 Other (Specify) Wilmington, Delaware 21. Signature of Faceral Service Licensee 19803 2506 Concord Pike Wilm DE Chandler Funeral Home 23a. Part Filler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each light Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** neumonia 3 days disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) P.O. Box 68760. signed by the attending physician be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 💆 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown certificate has been si rector, page 2 should ! Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 2□No 1∐ Yes 2**X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Division or Vital Records,

funeral director, After death. within 24 hours after death

To the Funeral Director: completely filled in by the f ō Hospital

State Registrar

Medical

29b. Signature apolitile of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month. Dav. Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

5 Pending

6 Could not be determined

investigation

1 Natural

2 ☐ Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only

22. Registrar's Signature

Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #19a. per FH 5/27/09 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day **Physician** JOYCE 19 2009 12:49 P M LAVERNE JAY MAY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL MONTGOMERY TAKOMA PARK 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, **Funeral** Year) Hours Months Days 1 □ M 2 □X 14 1943 WASHINGTON, DC 65 Director 579-56-2114 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 □ No Director PRINCE GEORGE'S UPPER MARLBORO 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with transt of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or Items 23a or it yo or other traumatic event, the Medical Exprining must be not 1077 LARGO ROAD # 305 20774 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🛛 No BLACK Completed by Specify: 3 ☐ Widowed 4 🂢 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) POST OFFICE GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHAUNCEY J. FISHER BEULAH JOHNSON ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BETT: FISHER/DAUGHTER Beverly Am Fisher 529 SOMERSET PLACE N.W. WASHINGTON, DC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If ite
any Injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State LINCOLN CEMETERY 5/23/2009 SUITLAND, MARYLAND 4 Donation 5 □Other (Specify) J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical ue to (or as a consequence of) Examiner rotic Cardiovascular discore Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ⁹ Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
¹⁰ Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P,O. Box 68760, Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ⋧ 1 Yes 2 1 Ne 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 ☐No 1 ☐Yes 2 XINo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2. No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Natural investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the I within 24 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20060100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAHMINA

(1) (INIVESIT BLVD Seat SILVESPT NO 31. Date filed (Month, Day, 1987) MAY 2 1 2009 32. Registrar's Signature Year) Registrar

21215-0036 Maryland Baltimore,

Physician /Medical Examiner

P.O. Box 68760, Division of Vital Records,

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 5 Year A M Joyce Marie Knight 1:00 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 5000 Lydianna Lane Suitland 5 4 1 Prince George's 8. Date of Birth (Month, Day, Ye Sept. 28, 9. Birthplace (Sta If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number 6. Sex Year) 1943 Months Days Hours Min. 1 M 2 XF Sept. 577-58-0609 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 X Yes 2 □ No Maryland Prince George's Suitland [] 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20746 5000 Lydianna Lane Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ∐Yes 2 MaNo If Yes, Give Year or Dates: 1 Never Married 2 Married African b 1 ☐Yes 2 XNo Specify Specify: 3 Widowed 4 Divorced American 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Custodial Engineer Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any lighty or other traumatic event once. Be Theresa Emily Thompson William Peter Brooks မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19c. Marvland 20720 19a. Informant's Name/Relationship (Type. Print) Bowie, Maryland 4017 Windflower Way Rhonda A. Thomas/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 MBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) \ Olivet Cemetery May 21, 2009 Washington, DC 21. Signature of Funeral Service 22. Name and Address of Facility Stewart Funeral Home, Inc. Lice 4001 Benning Road N.E. Washington, DC 20019 23a. Part L Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or high rt failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final aV 0 ja (a disease or condition resulting in death) Due to (or as a consequence of): oronary Euguer tielly list our dition o, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely illied in by the Innertal director, page 2 should be detached for use as the burial-transit completely illied in by the funeral director, page 2 should be detached for use as the burial-transit esti Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ZNo Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? حک 24a. Was an autopsy performed? Yes 2 No 2 **N**0 1 □Yes 1 Tes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🔯 Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28h Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6400 Marlboro 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician
/Medica
Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, It is Medical Examinat must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

(541) Sta Registrar

	for State Registrar	State of W	aryland / L	Certific			J WEIRA		. No. 2	09	17808
an	1. Decedent's Name (First, Middle,	1 11 11	f a	101	iet.	L	2. Date Mor	of Death	Day	Year	3. Time of Death
cal ier	4a. Facility Name (If not institution,					Location of De		THY	<u>_</u>	2009 y of Death	00 7
ici	Carroll Hospital			We	stmins	ster			Carro	11	
	526-32-6455	5. Sex 7. Ag 1	ge (In yrs. last birt 78	Mont	der 1 Year hs Days		lin. 8. Date (Mo Aug	of Birth nth, Day, Y 23,	^(ear) 1930	9. Birth Coul Ariz	place (State or Foreign ntry) ONA
	Usual Residence of Decedent 10a. State 10b. County	·	10c. City, Town	or Location						1	10d. Inside City Limits
ctor	MD Carroll	<u>L</u>	Taneyt								1 AYes 2. No
ral Dire	10e. Street and Number 16 Taney Court				Zip Code 1787			US.	a. Citizen of A	What Cour	ntry?
Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☒ Widowed 4 □ Divorced	If Van Cive	?		cedent of H pecify Cuba 2 No	ispanic Origin? in, Mexican, Pi Specify:	' (Specify Yes lerto Rican, e	s or No- etc.)		ice - Americack, White, fy: Whi	etc.
pleted	15. Decedent's (Specify only highest	grade completed)		Decedent's U (Give kind of life. DO NO	work done of	during most of	working	16	6b. Kind of E	Business/In	dustry
Com	Elementary/Secondary (0-12)	College (1-4or	Hei	matolo	gist			H	ealth	care	
Be	17. Father's Name (First, Middle, La Omar Raymond Lov				ĺ	18. Mother's I		Middle, Ma	iden Surna	me)	
မ	19a. Informant's Name/Relationshi		19h	Mailing Addr	ess (Street	and Number of		Number (City or Town	State Zii	n Code)
	Lisa Lovett/daug					on Plac					, 5500)
	20a. Method of Disposition 1 ☐ Burial 2 🌠 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	B ☐ Removal from State	20b. Place of cemeter.			ory 05	Date /19/09		c. Location		
	21. Signature of Funeral Service Li	-		_		Cremat.		1			
_	Devely I	Heltle								ville	, MD 21029
	23a. Part 1. Enter the decase, or c shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	nly one cause on each I	ine.				diac or respir	atory arres	.t,		Approximate Interval Between Onset and Death
	resulting in death)	Due to (or as	Sept s a consequence of	of):	en s	~					2 days
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		a consequence of		. 07.12	~					2004
xami	Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of	of):							
Aedical Examiner		d	-								
Med	IF FEMALE:	00 1/									
Completed by Physician/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e or pregnancy 2□ Fetal death at time of death	3 ☐ Ectop 5 ☐ Other	ic pregnanc (specify)	у				ate of deliv Ionth	rery Day Year
oy Ph	Part II. Other significant condition	ns contributing to death I	but not resulting in	the underlyin	g cause give	en in Part I.	236	e. Did toba	cco use coi	ntribute to t	the cause of death?
ted							-	1 🗌 Yes	2 No	3 🗌 Pro	bably 4 Unknown
Comple								a. Was an autopsy performe Yes			opsy findings available ompletion of cause of
Be	25. Was case referred to medical examiner?	Hospital:			DOA Othe	26. Place of					
Medical Certification: To	1 ☐ Yes 2 No 27. Manner of Death Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury 28b. T	tpatient 3 ime of njury	28c. Injur Worl	y at	g Home 5 [28d. De		ce 6 □ O		fy)
ficati	2 Accident investigat 3 Suicide 6 Could no	ot be 28e. Place of In	jury - At home, far	rm, street, fac		Yes 2□No	28f. Loc	ation (Stre	et and Nun	ber or Run	al Route Number,
Certi	4 Hornicide	building, e	tc. (Specify)					or Town,			
dical	29a. Certifier 12 CertifyIng (Check only one) 2 Medical E	Physician: To the best xaminer: On the basis and manner s	of examination an	e, death occur d/or investiga	red at the tir tion, in my o	me, date and p pinion, death o	lace, and due occurred at th	e to the cau e time, date	use(s) and r e and place	manner as e, and due t	stated. o the cause(s)
Me	29b. Signature and title of certifier	·> 4			29c. Licens	e number		290	d. Date sign	ed (Month,	Day, Year)
	Mont	Silvo	MD		DOO	647	32		5/	17/	09
	Marth F. Br				100.0	AUE	(1) 100	1	alco	MA	71107
te	31. Date filed (Month, Day, Year)		ar's Signature	Sank	NICKINI!	rive	W 62	min	1212/	1110	7119
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Registrar
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State

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Registrar's Signatur

Ana Rubio MD.

31. Date filed (Month, Day, Year)

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notifled at

traumatic event, the Medical

should be Mental

Health tem 27

Department of Important: If it any Injury or conce.

/Medical

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cate has been signe page 2 should be

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within 24 hours after death To the Funeral Director:

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Physician:

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 22, 2009 Month **Physician** 12:20 AM Frank Julius Morvan May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Aug. 11, 1926 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1XM 2□F 209-20-0238 82 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Harford Funeral Director MD White Hall 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 5336 Norrisville Road 21161 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify: White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electric Company Electrician 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Julius Morvan Delcie Manspeaker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5336 Norrisville Rd., White Hall, MD 21161 Ida M. Morvan/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)

New Freedom

Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition May 27, 1 X Burial 2 □ Cremation 3 X Removal from State New Freedom, PA 2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DISSOCIATION Immediate Cause (Final ELECTRO MECHANICAL disease or condition resulting in death) Due to (or as a consequence of): RENAL FAILIRE ACUTE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Clustridium Difficile Colitis Due to (or as a consequence of): LOUKABMIA HONIC LYMPHO-COTIL Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2D No 24a. Was an 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Medical Certification: 12 Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29c. License number 29b. Signature and title of certifier MD D26191 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , 260 GATEWAY DRIVE, SUITE 21/22B, BELAIR, MD 21014 DANUSHA, SIRITHAGA 31. Date filed (Month, Day, Year)

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 5-28-2009 **Physician** 10:30 A M George W. McCain /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Frederick Buckinghams' Choice Health Care Ctr Adamstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
2-1-1923 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F 86 291-18-8644 Director OH Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 □Yes 2 X No Director Frederick Adamstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code **USA** 21710 3200 Baker Circle Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 42–45 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No 2 Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any Injury or other traumatic event, the Medica once. Elementary/Secondary (0-12) College (1-4or 5+) Washington DC Fire Department Fire Fighter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jesse Brettell Elwood McCain ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 3200 Baker Circle Box 220 Adamstown MD 21710 McCain Norma 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 6-1-2009 Silver Spring, MD 21. Signature of Fune al Servi dicen 22. Name and Address of Facility Keeney & Basford P.A. F.H. 106 East Church St Frederick, MD 21701 M01176 lar 20a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Heart Failure **Physician** ongestive /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. ned by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 2 No 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1∐Yes 21⊠No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. To the I within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5-29-09 D0058726 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yvette Warren Myersville MD 3000D Ventrie Ct. 21773 31. Date filed (Month, Day, Year) State JUN () 3 **200**9 Registrar

State of Maryland / Department of Health and Mental Hygiene 2009Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** May 26, 2009 Virginia Irene Mellott 10:45 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hancock

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Months | Days | Hours | Min. | July 24, 1929 3510 Western Pike Washington 5. Social Security Number Birthplace (State or Foreign Country)
 WV 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F 79 Director 218-24-9266 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d Inside City Limits "natural", or Itams 23a or 28a-f show 1 ☐ Yes 2 ☑ No Washington Hancock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 靣 3510 Western Pike 21750 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ White 3 □ Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) r than Elementary/Secondary (0-12) College (1-4or 5+) 12 Seamstress Clothing Manufacture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Fred T. McInturff Erma Clingerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lester G. Mellott/Husband 3510 Western Pike Hancock, MD 21750 Pages 1 at nent of Heal. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: if any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Mays Chapel Cemetery 05/29/2009 Warfordsburg, PA 22. Name and Address of Facility 141 West Main Street 21. Signature of Funeral Service Licensee Grove Funeral Home, P.A. Hancock, MD 21750-0368 Love Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or confinitions that caused t shock, or heart failure. List only one cause on each line ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Justan Canana month /Medical Examiner KNOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transi be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2000 3 ☐ Probably 4 ☐ Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 25 rector Be 25. Was case referred to medical 26. Place of Death (Check only one, Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 1 ☐ Yes 28 No Other: 4 Nursing Home 5 esidence 6 Other (Specify) ္ရ ŧ 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (IM 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JUN 0 3 2009

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U U 9

					State of IV	iai yiai i		ertificate of	Death		Reg. No.		1 10 10	
ı			1. Decedent's Name (First, Mic	idle, Last,)					2. Date of Dea		Year	3. Time of Death	_
	Physici /Medic		Virgil Raymor	nd Mi	ller					May		009	11:52 PM	1
gara.	Examir		4a Facility Name (If not institut	ion, give	street and number	r)			4b. City, Town, or L	ocation of Death				
			123 W. Center				0akland				Garr			
	Funeral Director		5. Social Security Number 215-26-6353 Usual Residence of Decedent	6. Sex	7. A	nge (In yrs. i	last birthday Yrs.	Months Days		8. Date of Bird (Month, Da July 24			place (State or Foreign htry) y land	
	land		10a. State 10b. Cour	ity		10c. City	, Town or L	.ocation				1	0d. Inside City Limits	_
	Mary F sh	to	MD Garı	ett		0ak	land						1只Yes 2□No	
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	r dea	ner	11. Marital Status		12. Was Deceden	t Ever in U,	S. 13.	Was Dacedent of If Yes, specify Cut	Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or No Rican, etc.)	- 14. Rac Blac	e - Americ	can Indian, etc.	
0200-91212	be filed within 72 hours after death with the Maryland nial Hygiene. Id other than "natural", or Items 23a or 28a-f show event, The Medical Examinet inset be notified at	To Be Completed by Funeral Director	1 ☐ Never Married 2X M 3 ☐ Widowed 4 ☐ Divorc		1 ☐ Yes 2 ∑ If Yes, Give Year or Dates	No		1□ Yes 2X No			Specify			
2-0	72 ho	eted	15. Deced (Specify only high	ent's Edu	cation e co <i>mpleted</i>)		16a. Dec	edent's Usual Occu	pation during most of worked)	king	16b. Kind of Bu	usiness/In	dustry	
7	vithin ne. hen e	щ	Elementary/Secondary (0-12	-	College (1-4o	5+)					m			
	iled w dygiel her ti	ပိ	12 17. Father's Name (First, Middl	le (act)			Tru	ck Drive	18. Mother's Nam	ne (First Middle	Transp		lon	_
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Ξ	d 2 should be th and Mental 7 is marked o traumatic eve	ř	19a. Informant's Name/Relatio		pe. Print)		19b. Mai	ing Addrass (Stree	t and Number or Ru		0 2	State, Zip	Code)	_
Ž	and 2 sealth ar n 27 is		Cynthia Miller					-	er St., 0a					
ē,	other tr		20a. Method of Disposition			20b. P	lace of Disp	osition (Name of ematory or other pla	ace)	Date	20c. Location -	City or To	own, State	
Ē	Pages 1 and ment of Health ant: If item 27 jury or other t		1 ☐ Burial 2 X Cremation 4 ☐ Donation 5 ☐ Other		emoval from State	8		nd Crema		5/18/09	Cumber	1and	, MD	
Baltimore, Maryland	permit. Pag Department Important: fl any Injury o		21. Signature of Funeral Service	e License	90		2		ess of Facility Burdock	Funeral				
-			23a. Part1. Enter the disease, shock, or heart failure. L	or compli	cations that cause	ed the death	n. Do not e		cond St.,			21550	Approximate Interval Between	_
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VITAI IN	cian: ertific actor,	Be	25. Was case referred to medic examiner?		lo amiha l				26. Place of Dea	th (Check only o	ne)			
0	hysi this c	2	1 ☐ Yes 2 ☐ No 27. Manner of Death		lospital:		ER/Outpation 28b. Time	ent 3LI DOA		ome 5 Resid	dence 6 Oth		<u>'ý)</u>	_
	Jing F h. After funer	tion	1 ☑ Natural 5 ☐ Pend	ding stigation	28a. Date of In (Month, D	ay Year)	I n jury	Wo	ork?]Yes 2□No	28d. Describe	low injury occur	180		
DIVISION	deatl ctor: by the	fica	3 ☐ Suicide 6 ☐ Coul	-	28e. Place of Ir	njury - At ho	me, farm, s	treet, factory, office				er or Run	al Route Number,	_
2	after after Dire	Certification:	4 Homicide	, , , , , , , , , , , , , , , , , , ,	building, e	etc." (Specify	/)			City or Tox	vn, State)			
	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical C				of examinat			ime, date and place opinion, death occu					
	Nithin Vithin To the	Me	29b. Signature and title of certif	fier 4	. 4				se number		29d. Date signe			
			•	to	1			T)1533	3	5/18	5100	7	
•	**	.	30. Name and address of person	on who co	mpleted cause of	death (Item	23a) (Type							_
		4	Thomas G. Joh						, Oakland	, MD	21550			
	Sta Registr	_	31. Date filed (Month, Day, Yea	9 20	09 32. Regis	trar's Signa	ture A	back						

State of Maryland / Department of Health and Mental Hygiene 0 0 = For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician May 13, 2009 6:20 P M Beatrice E. Miller /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frostburg Allegany Frostburg Village Nursing Home Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 💢 F June 25, 219-03-9645 89 1919 Maryland Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or itame 23a or 28e-f ehow pruner roughbandified at 1 XYes 2 No Garrett Oakland Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21550 USA 619 E. Oak St. filed within 72 hours after death Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "netural", or 1 Yes 2 No Specify: þ 3 X Widowed 4 ☐ Divorced White Completed Medical 16b. Kind of Business/Industry 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Operator Telephone Company 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fil ment of Heelth and Mental H tent; If Item 27 is marked off jury or other traumatic even Charles Frazee Daisy Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Craig A. Miller/Step-Son 12340 Cash Valley Rd., NW, Cumberland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important; If eny Injury or once. Blooming Rose Cemetery May 15, 2009 Friendsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Famility Newman Funeral Homes, P.A. 21. Signeture of Euneral Service Licensee P.O. Box 275, Grantsville, MD 21536 amace Part1. Enjer he disease, o shock, o heart failure. Li complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) **Physician** CONGESTIVE 1HEART /Medical Due to (or as a consequence of) Examiner CORDNARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine The law requires thet the death certificate be executed the attending physicien end thed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Ulnknown δ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 Yes 2 No To the Hospitel or Attending Physician: To the Funeral Director: After this certific completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No ۵ 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No M 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funerel Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year, 29b. Signature and title of certifier D26907 Hidu 14,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harjit Sidhu, 925 Bishop Walsh Rd., Cumberland, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 18 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month 2009 **Physician** Mary C. Mudzinski 12:30 AM May 18, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Morningside House Laurel If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2**X** F Dec 31, 1915 Rhode Island Director 096-09-5369 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland in and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show raumatic event, it is Marited Exercited The Property of the Marited Exercited The Property of the Marited Exercited The Property of the Marited Exercited The Property of the Marited Exercited The Property of the Marited Exercited The Property of the Marited Exercited The Property of the Marited Exercited The Property of the Marited The Property of the Marited The Property of the Marited The Mar 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 □ No Director Prince George's Laurel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20707 7700 Cherry Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: If Yes, Give Year or Dates: Specify: White Completed by 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anelia Pietrasvska Albert Frodyma Pages 1 and 2 should ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any injury or other trau once. 2935 Jessup Rd. Jessup, MD 20794 Joan Marie Steffens/daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State W. Arundel Crematory 05/20/09 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Coing Homes Cremation Service P.O. Box 784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death acute Immediate Cause (Final Myocardial Infarction **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) be executed sician and burial-trans Due to (or as a consequence of) aftending physician for use as the buria Box 68760 Physician/Medical law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death 5 ☐ Other (specify) signed by the a the detached f o 9 Unknown 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖺 Unknown <u>Diabetes Mellitus</u> Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has e 2 autopsy performed? Yes 2 No page certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Yother (Specify) living 1 Tes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) After th funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending n 24 hours after death.

ne Funeral Director: A
pletely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the 29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifier

Luis A. 31. Date filed (Mont) 1000

Casas, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14201 Laurel Park Dr. #103 Laurel, MD 20707

29c. License number D24997

May 19, 2009

09-03935 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Andrew Mackall State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death Physician/ Month Day May 17, 2009 Year 1700 hrs Andrew Gerard Mackal1 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 6222 Franklin Gibson Road Tracey's Landing 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Director Months Days Hours Min 217-43-8804 11/18/1987 21 1 X M Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits MD23a or 28a-f show notified at once. Anne Arundel Tracy's Landing Yes 2 X No permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6222 Franklin Gibson Road 20779 USA Funera 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes 2X No Specify: Black Widowed Divorced If Yes, Give Year Yes 2 X No specify. ð 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Warehouse Worker Food Service 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ray Mackall Patty Jones Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0779 19a. Informant's Name/Relationship (Type, Print) Ray Mackall/father 6222 Franklin Gibson Rd. Tracy's Landing, MD 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Carter' s UMC Cem. 5/22/2009 Friendship, MD Donation 5 Other Specify 22. Name and Address of Facility Sewell Funeral nature of Funeral Service Licens Home 1451 Dares Beach Rd. Prince Fred., MD20678 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical aGunshot wound of head Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical AMENDED 23a,27,28a-f,perME G892 6/8/09 TT X UNPENDED attending physician or use as the burial 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy Month Live birth Day Fetal death past 12 months Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown detached for Unknown Part II Other significant conditions antributing to death but not reculting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death?

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death To the Funeral Director;

	ig cause given in tarri.	1 Yes 2 🗸 N	No 3 Probably 4 Unknown
		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical	26.Place of Death (Check on	ly one)	
examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	DOA Other Nursing I	Home 5 Residenc	e 6 🗸 Other: Scene
27. Manner of Death 28a. Date of Injury 28b. Time of Injury	28c. Injury at Work? 28	8d. Describe how injury	occurred
1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation Fd 5/17/09 Fd 5:00 pm	1_ Yes 2 X No S	ubject sho	t self
3 X Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, facto	ry, office building, etc. 28	Bf. Location (Street and	Number or Rural Route Number, City
4 Homicide determined (Specify) house	l _R	d Tracey's	222 Franklin Gibso Landing MD
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the	ne time, date and place, and du	ue to the cause(s) and r	manner as stated.
one) 2 Medical Examiner: On the basis of examination and/or investigation, in rand manner stated.			
29b. Signature and title of certifier 2	9c. License number	29d. Da	te signed (Month, Day, Year)

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, State Registra

Ana Rubio MD.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

May 18, 2009

Death

Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** Arlonia Perry Myers May 20, 2009 12:26 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's 7915 Grant Drive Glenarden Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, April 7, **Funeral** Months Davs Min. Hours 1 □ M 2 □XF 1920 North Carolina Director 89 579-24-1244 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County ral", or items 23a or 28a-f shov Exp. itings must be scottified at 1X Yes 2 No Director Glenarden Maryland Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with 20706 USA 7915 Grant Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 Tyes 2 2700 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No 2 If Yes, Give Specify. Specify: Black 3 Widowed 4 Divorced Year or Dates: "natural". Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 2+ ould be filed within Mental Hygiene. than. Elementary/Secondary (0-12) Private Registered Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Ora Mae Tabron 1 and 2 should b Health and Ment Ransom Sidney Perry 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) : If item 27 i 7915 Grant Drive, Glenarden, MD 20706 (Granddaughter) Arlene Boateng Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. 5/26/2009 Harmony Cemetery Landover, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Latimore Funeral Services, P.A. 21. Signature of Funeral Service License 9013 Annapolis Road, Lanham MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 2 weeks Sessis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-trar resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the hurial Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) 1 ☐ Yes 2 🗷 No 9 Unknown bed by 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by Diabetes Mellitus 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Atherosclerosis autopsy performed? certificate 2 🔯 No 2 No 1 □ Yes 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: 4 \(\text{Nursing Home} \) 1 \(\text{Nesidence} \) 6 \(\text{Other} \) (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division or Attending 1 XNatural 5 Pending n 24 hours after death.

The funeral Director: Af oletely filled in by the fun 1 ☐Yes 2 ☐No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2.

State Registrar 29b. Signature and title of certifier

Stephanie Trifoglio, M.D. . 32. Registrar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

037934

7500 Greenway Center Drive, Greenbelt MD 20770

29d. Date signed (Month, Day, Year)

May 20, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Ameno#'s 7.8. PerFam. PCC5-26-09cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Yea 140a 001 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Richey Joseph K Social Security Number Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/24/1936 9. Birthplace (State or Foreign Country) New York Washingtonville 6. Se . Age (In yrs. last birthday) **Funeral** Year)1937 Months 1 ☑ M 2 ☐ F Days Hours Min. 71 Yrs. Director <u>515-32-</u>7042 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than 'natural', or items 23a or 28a-f show other traumatic event, the Modical Extrairer must be notified at 1X Yes 2 □ No Directo Maryland Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11100 Brookdale Lane Funeral 20772 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Armed Forces?
1 XYes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐Yes 2X No Specify ð Specify: 3 X Widowed 4 ☐ Divorced Black Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Nental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Shuttle Service Airport Shuttle 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be be f 2 Morris H. Mann Martha Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Franklin Mann / Brother 12 Mann Lane Campbell Hall, New York 10916 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If iter
any injury or otl 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/29/2009 Cheltenham, Maryland Maryland Veterans 22. Name and Address of Facilit Pope Funeral Homes. P.A. 21. Signature of Funeral Service Licenta 101085 5538 Marlboro Pike Forestville, Maryland 20747 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a consequence) of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of The law requires that the death certificate be executed Due to (or as a consequence of) as the burial-P.O. Box 68760. physician Completed by Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Por in the past 12 months? Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Tinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 🗆 No 1 □ Yes 2. 1 🗆 Yes Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2√No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Hospice 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 5 ☐ Pending investigation 1. Natural 1 □Yes 2 □No 2 Accident 24 hours after deat Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultimare Mo - BUDING! aren 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death Decedent's Name (First, Middle, Last, Henry P. Nastick, Date of Death 3. Time of Death 12:48 P_M 2009 Physician /Medical 4a. Facility Name (If not institution, give street and number) 812 John Smith Street 4b. City, Town, or Location of Death 4c. County of Death Examiner Havre de Grace Harford 9. Birthplace (State or Foreign MORY) Land 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 1X M 2□ F 8. Date of Birth 0 (Mg/m/h5Day, 199760 **Funeral** Months Days Hours Min 219-84-1719 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Maryland Harkord Havre de Grace 1 Yes 2 □ No Director 10g. Citizen of What Country? United States of America 10g. Street and Number 812 John Smith Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify. Specify: White ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

Crab Steamer Elemenary/Secondary (0-12) College (1-4or 5+) Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Henry P. Nastick, Sr. Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 619 Hoppers Lane, Havre de Grace, Maryland 21078 McChael's Nastler (Brother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State R.A. Ferris & Co. Inc 05/28/2009 West Chester, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Zellman Funeral Home, F.A. 21078 PT. Signature of Funeral Service Licenses 123 S. WashingtonSt. Havre de Grace, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myoca disease or condition resulting in death) /Medical Due to (or as a sonsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transi physician and the burial-trans Due to (or as a consequence of) Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month 5 Other (specify) P.0. the 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has t autopsy performed? certificate 1 □Yes 2 ☑ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? or Attending 1 Hatural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 05/28/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 16 A.MROWIEC Aberdeen Plane Abendeen MA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 741 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner George 6. Sex Georg 25 never 1405 Tou 5. Social Security Number f Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdav) **Funeral** Date of Birth (Month, Day) Year) Hours 1⊠M 2□F Days Yrs Director 63 9/20/1945 230-56-4742 Hampton, VAUsual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar mist be notited at 1√TYes 2 □ No Directo Maryland Prince George's Mitchellville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Funeral 12511 Kingstead Court 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 MYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: <u>۾</u> Specify: Black 3 Divorced 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U. S. Postal Services 12 Mail Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Thurman Overby Vassie Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12511 Kingstead Court Mitchellville, MD 20721 Perry Overby / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans 5/26/2009 Cheltenham, Maryland 22. Name and Address of FacilityPope Funeral Homes, P.A. Signatur of Funeral Service Licen once 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Enter the disease, or com shock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line Immediate Cause (Final disease or condition resulting in death) Atherosc **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): physician Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 5 ☐ Other (specify) 2 □No ∃Yes Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed this certificate has been s al director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 \square No 1 ☐Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner 1 Yes Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA after death.

Director: After this d in by the funeral d 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled i Medical 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 VSTK 31. Date filed (Month 32. Registrar's, Signatu State Registrar

		4	1 - State of Maryla Registrar	•	artment of H rtificate of I			2003	17821
			Registrar 1. Desedent's Name (First, Middle, Last)	Cei	tilicate of t		Reg. 2. Date of Death	No.	3. Time of Death
	Physicia /Medic		William closup Pulas	5			May &	BY INTO	6:47 AM
	Examin		4a. Facility Name (If not institution, give street and number)	11 1	4b. City, Town, or	Location of Death	,,,,	4c County of Death	
			Marrett Co. Memorial Ma	spital	Canlo	If Under 24 Hrs.)	Larre	X1
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In y	vrs. last birthday) Yrs.	Months Days	Hours Min.	B. Date of Birth (Month, Day, Ye	ar) 9 Birti	hplace (State or Foreign untry)
Ε.	ס		Usual Residence of Decedent	11			05/05/	TOO V	V -
	arylan ehow	_		. City, Town or Lo	ecation				10d. Inside City Limits ty□kYes 2 □ No
	the M	Director	WV Preston	Terra A	Alta 10f. Zip Code	_	100	Citizen of What Co	
	with With		307 Maple Avenue				iog.	U.S.	unity
	death ms 2:	Funeral	11. Marital Status 12. Was Decedent Ever in		26764 Was Decedent of H	spanic Origin? (Spec	ify Yes or No-	14. Race - Ame	
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelip and Mertall Hyglene. Important: If term 27 is marked other than "natural", or items 23a or 28s-f show important: If term 27 is marked other than "natural", or items 23a or 28s-f show eny injury or other traumatic event, the Medical Examinat must be notified at once.	by Fu	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ Your Sirver Sirver Sirver Year or Dates:		r Yes, specify Cuba 1 ☐ Yes 2 🕱 No	n, Mexican, Puerto R Specify:	ican, etc.)	Specify: Wh	
21215-0036	72 hou	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupa	ation	165	. Kind of Business/	Industry
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22	Hygier Hygier Ther th		12 17. Father's Name (First, Middle, Last)		Welder	18. Mother's Name	(First Middle Main	Indust	rial
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Maryland	should and Men marke umatic	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street a	and Number or Rural	Route Number, Ci	ty or Town, State, 2	Zip Code)
	and 2 eelth a m 27 ie		Rebecca Pyles/Spouse	307	Maple A	venue, T			
Baltimore,	Pages 1 nent of H int: If iter iry or oth		· (The in a Classical Clas	b. Place of Dispo cemetery, cren erra Alta (natory`or other plac	e) Da		Location - City or	
Ħ	it. Pa intmen intant: njury		4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ture 1 Funeral service Licensee		2. Name and Addres		/2009	Terra A	Ita, WV
Ba	Departicular Depar		Mark C. Speen	- 1	rthur H 05 High	Wright land Ave	Funera Terra	l Home	WV 26764
П			23a. Part1. Enter the disease, or complications that caused the d shock, or heart failure. List only one cause on each line.	eath. Do not ent	er the mode of dyin	g, such as cardiac or	respiratory arrest,		Approximate Interval Between
Œ	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ren	al	faclus	e		Onset and Beath
	Examiner		Due to (or as a con:	sequence of):	10/00				2 days
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	acuted nd transit	Examiner	cause. Enter Underrying Cause (Disease or injury that initiated events c.						
8760,	cate be executed physician and the burial-transit	E	resulting in death) Last Due to (or as a cons	sequence of):					
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×	h certi anding use a	M/U	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ F		Ectopic pregnancy			23d. Date of deli	ivery
P.O. Box	The law requires that the death certificate be executed ste has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown in the past 12 months? 4 □ Pregnant at time of 9 □ Unknown		Other (specify)			Month	Day Year
<u>.</u>	res thet the signed by be detacted	y Ph	Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?
Vital Records,	w requires been sign should be		Atreal tilorillation	77			1 ☐ Yes	2 100 3 Pr	obably 4 Unknown
ဝင္ပ	law requas been 2 shoul	Completed					24a. Was an autopsy	24b. Were au	itopsy findings available completion of cause of
<u> </u>	The sete h	Com					performed	death?	2 No
Vita Vita	vician certific rector	Be	25. Was case referred to medical examiner? Hospital:		Other	26. Place of Death			
ō	Phys or this oral di	٤	1 ☐ Yes 2 ☐ No	2 ER/Outpatien 28b. Time of	IL 3L DOA	4 Nursing Hom	e 5 🗌 Residence 3d. Describe how i	e 6 Other (Specinjury occurred	cify)
on	nding ath. r: Afte e fune	atior	1 ➡Natural 5 □ Pending (Month, Day Year 2 □ Accident investigation	r) Injury	Worl	k? Yes 2 □No		• •	
Division of	l or Atte efter de Directo d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Hornicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Sp.	t home, farm, str	eet, factory, office	29	Bf. Location (Stree City or Town, S	t and Number or Ru Itate)	ural Route Number,
_	S is o	alCe	29a. Certifier 1 Certifying Physician: To the best of my	knowledge, death	occurred at the tin	ne, date and place, ar	nd due to the caus	e(s) and manner as	stated.
	the Hin 24 the Fu	Medical	one) and manner stated.	lination and/or in	1				
	F 3 F 8	_	29b. Signature and title of Conflict	9	29c. Licenso	1246	4	Date signed (Monti	109
			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	1 4		1-1	/ - (
			Sotiere Savopoulos, MD 255 N. 31. Date filed (Month, Day, Year) 32. Registrar's Si	. Fourth	St., Sui	te 1, Oak	land, MD	21550	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 2 9 2009 32. Registrar's Si	A. A	arke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month BARBARA A. PAYNE Mai 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner at Easton EASTON Memorial Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2**XX** 396-50-6086 60 Director AUG 24, 1948 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the fixed Experience must be notified at Director MD TALBOT ST. MICHAELS 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? filed within 72 hours after death with 807 CALVERT AVE. 21663 Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes ZXNo 1 Never Married 2 married Maryland 21215-0036 1 □Yes XXNo If Yes, Give Year or Dates: Specify. Completed by Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Barbara 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) BUSINESS OWNER CLEANING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be ROBERT CHYCINSKI DOLORES **GUZIKOWSKI** ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 807 CALVERT AVE. ST. MICHAELS, MD 21663 HUSBAND JOHN M. PAYNE Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State Department of I-Important: If ite any Injury or otl XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN MEM PARK 5-20-2009 EASTON, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNEAL HOME, P.A. 200 S. HARRISON ST. EASTON, MD 21601 MERCERON CHOIL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Due to (or as a consequence f): disease or condition resulting in death) /Medical Examiner Sophageal if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 0 5 Other (specify) 1 ☐ Yes 2 X No 9 Unknown 9 Unknown ۵

23d. Date of delivery Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , MD Purdy Street 2160 mo 32. R 2009

Year

Talbo

USA

2009

0524 AM

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Low

6 months

1 ☐ Yes 2XXNo

State Registrar

6

of Vital Records,

Division

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To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death _2009 May 16, **Physician** 9:30 A.M Donald Kaye Palmer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Chevy Chase 5404 Greystone Street 8. Date of Birth (Month, Day, Year) DeC 18, 1923 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 XM 2 □ F Michigan Dec. Director 362-24-3652 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It Mindical Eran. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County **Funeral Director** 1X Yes 2 □ No Chevy Chase Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20815 5404 Greystone Street 12. Was Decedent Ever in U.S. Armed Forces? 1 Zives 2 □ No If Yes, Give Year or Dates: 1943–46 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 🛣 Married Specify: ģ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
Deputy Assisticant Secretary for 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Federal Government Economic Affairs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Donald Emerson Palmer Ruth A. Ferigan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1327 S. Sheridan Drive Bloomington, IN 47401 19a. Informant's Name/Relationship (Type. Print) Jeffrey D. Palmer/son 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 05/19/2009 Odenton, MD W. Arundel Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Colonga Homes Cremation Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Prostate Cancer 10 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed nding physician and resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of performe 1 □Yes 2 ☑No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 A Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 1 ☐ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death.

To the Funeral Director; Af completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier (Check only Medi 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 19, 2009 MD 15128 mo 30. Name and addr is of person who completed cause of death (Jkm 23a) (Type, Print)

141 State

Box 68760,

Division of Vital Records, P.O.

Registrar

31. Date filed (Mont/LIDA

Gary M. Koritzinsky,

2141 K Street NW #407 Washington, DC 20037

M.D.

32. Registrar's Signature

	60.00	10.	1. Decedent's Name (First, Middle, Last)			2	Date of Death	Day Van	3. Time of Death
-	Physici /Medic		Viola So	ohia Rei	s	N	Month 17	2009	12:22 P M
	Examir		4a. Facility Name (If not institution, give street and no	mber)	4b. City, Town, o	r Location of Death		4c. County of Death	
7			Calvert County Nursing			Frederick		Calvert	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birtha	Months Days	Hours Min.	Date of Birth (Month, Day, Ye	ear) Coui	place (State or Foreign ntry)
period.	Director		Usual Residence of Decedent	93 Yrs)2-11-19	16 New	York
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		10a. State 10b. County	10c. City, Town o	r Location				10d. Inside City Limits
		to	MD Calvert		Prince 1	Frederick			1 ☐ Yes 2 X No
		irec	10e. Street and Number		10f. Zip Code		10g.	. Citizen of What Cou	ntry?
		al D	85 Hospital Road		20	0736		USA	
		y Funeral Director	Armed F		 Was Decedent of H If Yes, specify Cuba 	lispanic Origin? (Speci an, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Americ Black, White,	
36			1 Never Married 2 Married 1 Yes If Yes, G 3 Widowed 4 Divorced Year or		1 ☐ Yes 2 🎇 No	Specify:		Specify:	
Maryland 21215-0036		Completed by	15. Decedent's Education	16a. De	ecedent's Usual Occur	pation	16	whi b. Kind of Business/In	
5.		plet	(Specify only highest grade completed	(1-4or 5+)	Give kind of work done fe. DO NOT use retired	during most of working d)			,
212		E O	12 College	· · · · · · · · · · · · · · · · · · ·	memaker			own hom	ie
b		Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name (i	First, Middle, Mai	iden Surname)	
Jai		To I	Arthur August Piepl	ow		Annette		Hutte	er
lan			19a. Informant's Name/Relationship (Type. Print)		Mailing Address (Street			•	·
	1 and 2 Health em 27 i	- 8	Carol A. Grimstead, da		25 Yellow I	Bank Road,			
Ö			20a. Method of Disposition 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from	State cemetery,	crematory or other pla	ce)	.	c. Location - City or T	
Baltimore,	t. Pa rtmer rtant: rjury		4 Donation 5 Other (Specify)	Metropo	litan Crem				
Bai	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee			Na		eral Home,	
	uecellari		23a. Part1. Enter the disease, or complications that	caused the death. Do not		Harmony La:			Approximate
	Physician /Medical Examiner pnual-transit		shock, or heart failure. List only one cause on Immediate Cause (Final	each line.		•	· - ' -		Interval Between Onset and Death
			disease or condition resulting in death) a. Due to (or as a consequence of):						
6			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events b. Due to (or as a consequence of): C						
		Jer							
		Examin							
Ő,	e exe ian a urial-1		resulting in death) Last Due to	(or as a consequence of)	:				
68760,	ate b	an/Medical	d						
9 ×	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	/Me	IF FEMALE: 23c If yes o	utcome pf pregnancy				Old Date of dali	
Вох		Physic	in the past 12 months?	birth 2 Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of deliving Month	Day Year
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Δ			Part II. Other significant conditions contributing to	death but not resulting in th	he underlying cause giv	en in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
rds		ed by				_	1 ☐ Yes	2 No 3 Pro	bably 4 □Unknown
ပ္တ	aw re is bee 2 sho	Completed					24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
Ä	The law	mo					performe	d? death?	2 □ No
Division or Vital Records,	Physician: The this certificate ral director, pag	Be C	25. Was case referred to medical examiner?			26. Place of Death (Check only one)		
		To	1 Yes 2 No Hospital: 1		atient 3 DOA Oth	Nursing Home		ce 6 □Other (Spec	ify)
	ffe an	iuo.	1⊠Natural 5 □ Pending (Mo	e of Injury 28b. Tin nth, Day Year) Inju	ury Wor		d. Describe how	injury occurred	
isio	Attending r death. ector; After by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 280 Place	e of injury - At home, farm		Yes 2 □ No	f Location (Street	et and Number or Rui	ral Route Number
Ξ	or A after Direct in by	ertif	4 ☐ Homicide determined buil	ding, etc. (Specify)	i, street, lactory, office	20	City or Town, S		arrionic stampes,
_	spital ours neral		29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mariner stated.						
		Me	29b. Signature and title of certifie	29c. Licens	29c. License number		29d. Date signed (Month, Day, Year)		
			114	D	033125			5-18-09	
1	NM		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)						
0	/' '/s		Jonathan Lowenthal, M.D. 110 Hospital Rd., #310, Prince Frederick, MD 20678						
	Sta Regist		31. Date filed (Month, Day, Year) 32.	Registrar's Signature	b. park	9			
Di			MAYZU/III	Lenewa)	4. jugares				
DHMH 17 Rev 1/2001									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

State of Maryland / Department of Health and Mental Hygiene? [] [] 9

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		•	For State Registrar	State of Ivial		Certificate d			Reg.		11020
	Physici	an	1. Decedent's Name (First, Middle, Las	()					Date of Death Month	Day Year	3. Time of Death
wind	/Medic	al	4a. Fecility Name (If not institution, give	street and number)		4b. City, Tow	n, or Location		05	4c. County of Dea	ath .
		•	Anchorage	Nursina		SQ115	5bur	der 24 Hrs. 8.	Date of Righ	WICO	mico rthplace (State or Foreign
	Funeral Director		214 10 0107	2 M 2 □ F 97	n yrs. last birth	Months Da		s Min.	Date of Birth (Month, Day, Ye 09/22/19	911 Ma	aryland
	rland low		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location		<u></u>	· · · · · · · · · · · · · · · · · · ·		10d. Inside City Limits
	Ba-f et	Director	Maryland Wicomi	со	Salis						1X Yes 2 No
	h with th	ai Dire	10e. Street and Number 105 Times Squar	e		10f. Zip Coo 218			10g.	Citizen of What C	ountry?
036	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Heelth and Mental Hyglene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show empty injury or other traumatic event, the Madical Examinat must be notified at ODGE.	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates:		13. Was Decedent If Yes, specify 0			y Yes or No- an, etc.)	14. Race - Am Black, Wh Specify:	
Baltimore, Maryland 21215-0036	ithin 72 ho ie. ian "natur i Medical.	Completed by	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de <i>completed)</i> College (1-4or 5+		Decedent's Usual Oc Give kind of work do life. DO NOT use re	one during n tired)	nost of working		o. Kind of Business	s/Industry nt shades
d 21	filed w Hygier Sther th	Col	17. Father's Name (First, Middle, Last)	-	Ov	mer/opera		other's Name (F	irst, Middle, Mai		ic bridges
ylan	should be and Mental marked o	To Be	Joshua Wallace S	mall					Cordrey		
Mar	and 2 sho selth and I n 27 ie mu		19a. Informant's Name/Relationship (William E. Small)	Type, Print) Jr/son	19b. 2]	Mailing Address (Str. 2 Mildale	e Dr.,	nber or Rural R Salisb	oute Number, Coury, M	ity or <i>Town, State.</i> D 21804	Zip Code)
ore,	Pages 1 and 3 nent of Heelth ant: if item 27 ury or other tr		20a. Method of Disposition	Removal from State	20b. Place of l	Disposition (Name of crematory or other CO Memoria	f place) a.T	Date		c. Location - City o	
Him	permit. Page Department of Important: if eny injury or once;		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		Park			5/19/0		Salisbury	Association
ö	Ded de de de de de de de de de de de de d				FSP	501 Snc	w Hil	1 Rd.,	Salisbur	y MD 218	304
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a	consequence o	():		has cardiac or re			Approximate Interval Between Onset and Death
68760,	lificate be executed g physicien and as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence ol): C. Due to (or as a consequence ol): d									
Vital Records, P.O. Box 68	The law requires thet the death certificate be executed to hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physiclan/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death	3 □Ectopic pregn 5 □ Other (specif				23d. Date of d Month	elivery Day Year
ds, P	signed by	Ď	Part II. Other significant conditions of	ontributing to death but	not resulting in	the underlying cause	given in Pa	art I.			to the cause of death? Probably 4 ©Unknown
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<u> </u>	ysicie iis certi directo	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \) No	Hospital: 1 Inpatien	t 2 ER/Out	patient 3 DOA		- 4	5 Residenc	ce 6 Other (Sp	pecify)
Division of	Attending Physicien: r death. ector: After this certifice by the funeral director, g	ation:	27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day			Injury at Work? 1 Yes 2		d. Describe how	injury occurred	
Divis	for Atteefter des Directo	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, lar (Specify)	m, street, lactory, of	fice	281	Location (Stree City or Town, S	et and Number or State)	Rural Route Number,
	To the Hospital or Attending Physicien: The I within 24 hours eiter death. To the Funerel Director: After this certificete he completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best of niner: On the basis of e and manner state	examination and	death occurred at the	ne time, date my opinion,	e and place, and death occurred	d due to the caus at the time, date	se(s) and manner a and place, and d	as stated. ue to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	1.D.			795			. Date signed (Mo	nth, Day, Year)
	.Als.		30. Name and address of person who Babulal Du 106	completed cause of de AW find ST	ath (Item 23a) (Type, Print)	ahu D	m M	0210	814	
	Sta	te	31. Date filed (Month, Day, Year)		's Signature	hadel	م د بر		1		

Registrar

MAY 19 2009

			1 - For State Registrar	State of Marylan		artment of rtificate o		and Me	-	giene Reg. No. 2	009	17826
	Physici	an	Decedent's Name (First, Middle, Last)	Diane Lee So	hura			2	2. Date of Dea Month 05	th Day	O9	3. Time of Death
+	/Medic Examin		4a. Facility Name (If not institution, give stre		nurg	4b. City, Town	, or Location o	of Death	05		unty of Death	1004 -
and the			WMHS BRADDOCK CA				ERLAND				ALLEGA	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year Months Day		Min.	B. Date of Birth (Month, Day Decemb	n , Yea <i>r)</i> er 05, 194	9. Birthi Coul	place (State or Foreign htry) Maryland
۰			Usual Residence of Decedent		ty, Town or Lo							0d. Inside City Limits
	Maryla f sho	tor	Maryland Alleg		ty, fown of Lo	cation	Mid	land			1X Yes 2 No	
	or 28a	Director	10e. Street and Number	arry		10f. Zip Code			1	10g. Citizen	of What Cour	ntry?
	ath wi			d Street, Apt. B			215					SA
0	filed within 72 hours after death with the Maryland Hydiene. Hydiene. Ither than "natural", or items 23a or 28a-f show ant, the Fedical Evantings must be notified at	Funeral	11. Marital Status 12. 1 ☐ Never Married 2 ☐ Married	Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No		Was Decedent of If Yes, specify Co		gin? (Spec , Puerto Ri	ify Yes or No- ican, etc.)	14.	Race - Americ Black, White,	
5-0036	ours a	d by	3 ☐ Widowed 4 ☑ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 □ Yes 2 X N	lo Specify:				ecify:	White
<u>,</u>	n 72 h "natu edice	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work file. DO NOT use retired)							16b. Kind o	of Business/In	dustry
Z1Z	d withi giene. er than	mo.	Elementary/Secondary (0-12)	College (1-4or 5+)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	20 1101 130 101	Waitre	ess			Rest	aurant
and	eve d	Be	17. Father's Name (First, Middle, Last)	TT - 2			18. Mothe	r's Name (First, Middle, I			
5	2 should be and Menta Is marked araumatic ev	은	19a. Informant's Name/Relationship (Type.	m Harrison Spike		ng Address (Stre	et and Numbe	er or Rural			Gallaghe	
, Mar	1 and 2 s Health ar em 27 is ther trau		Kimberly Drew -	*	TOD: Walli				nd, Midlot			,
ore	S = = 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem	20b. F		sition (Name of natory or other p		Da:	May 27,		on - City or To	
altimor	permit. Page Department of Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee			ourg Memori			2009			, Maryland
n	permi Depar Impor any ir		21. Signature of Funeral Service Licensee	1 holas	22		ast Main				enzie Fung, MD 2	neral Home P.A 1539
			23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one	ions that caused the deat cause on each line.	h. Do not ent	er the mode of o	lying, such as	cardiac or				Approximate Interval Between
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Cardiac	Arrh	ythm	ia					Onset and Death
	Examiner			OVOU av	uence of):	ythm	Dis	011	2			
	D #1	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a conseq	dence of):	1	10					
	and al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):							
04/9	cate be executed by sician and the burial-transit	lical E	d.	(,							
9	ing phi		IF FEMALE:						-	I		
20X	To use roughts or attending tripsician: The law requires may the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Mec	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of o	ıl death 3 [Ectopic pregna Other (specify)				23d.	Date of deliv Month	ery Day Year
5	by the	hysid	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	JOHN 3 E	Journel (specify)						
'n	res ma signed be dei	þ	Part II. Other significant conditions contrib	outing to death but not res	ulting in the u	nderlying cause	given in Part I.			_		he cause of death?
ecords	ding Finysician: The law requir h. After this certificate has been s funeral director, page 2 should	Completed							-			bably 4 Unknown
i G	te has age 2	dmo							24a. Was a autops perform	med?	prior to co death?	opsy findings available impletion of cause of
VIII	ertifica ctor, p	Be C	25. Was case referred to medical examiner?				26. Place	of Death (1 ☐ Yes (Check only on		1 ☐ Yes	2 1 100
5	this or	2	1 Yes 2 No Hos	1 ☐ Inpatient 2 ☐		I 3 DOA			e 5 Areside			fy)
SIOII	th. : After e funer	Certification:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	W.W	ijury at fork? □Yes 2□N	1	3d. Describe ho	ow injury oc	curred	
2	r Atter	tifica	2 Devicide 6 D Could not be	28e. Place of Injury - At ho building, etc. (Specif	I ome, farm, stro fy)	eet, factory, offic	e	28	If. Location (St	treet and No	umber or Run	al Route Number,
5	urs aft eral Di		000 Cartification 4 1 2 20 1/4 : 12 1					l lit				
1	e nos 1 24 ho e Fune letely	Medical	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examiner	an: To the best of my knoOn the basis of examina and manner stated.	ation and/or in	n occurred at the vestigation, in m	y opinion, dea	th occurred	nd due to the d d at the time, d	date and pla	ce, and due t	o the cause(s)
1	withir To th comp	Me	29b. Signature and title of certifier			29c. Lice	nse number		2	29d. Date si	gned (Month,	Day, Year)
			1 - 10-1	ni MD			5940	7		5/	26/00	7
		3	30. Name and address of person who comp	leted cause of death (Iten	n 23a) (Type,	Print) DRIVE	- (1	mbor	10.0	MT	210	\mathcal{L}^{rr}
	Stat		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ituro			11 62 60	W 01	1301	ر در	700
	Registra	ar	MAY 27 2009	(Isneway)	B. 100	30Ked						

	1. Decedent's Na	me (First, Middle,	Last)		Cel	rtificate of	Dealli	2. Date of De		201		3. Time of Death
ian ical	Clyde C	Calvin Sa	anner, Jr.					Month 05	22	O Ye	ear 9	0435
ner	4a. Facility Name	(If not institution,	give street and number,)		4b. City, Town, o	r Location of Deatl	า	4c.	County of I		
		Braddock		/l t4	t to bath afor A	Cumberland y) If Under 1 Year If Under 24 Hrs. 8, Date of B					lega	
	5. Social Security 213–24–6 Usual Residence	789	6. Sex 7. Ag 1 ☑ M 2 ☐ F	7/ 0 1				8. Date of Bir	, Yezr	9. Birthplace (State of County) Maryland		
	10a. State	10b. County		10c. City, To	own or Lo	cation					10d	I. Inside City Lim
Director	MD	Garre	ett	Fri	ends	ville						1 ☐ Yes 2 🔀
Dire	10e. Street and N		_			10f. Zip Code			_	zen of Wha	at Country	/?
eral		riendsvil		Form in II C	40.3	2153				JSA	A	. to elian
by Funeral		arried 2 🔀 Marrie 4 🗔 Divorced	12. Was Decedent Armed Forces? 1 Tyes 2 The Street	No		was Decedent of F If Yes, specify Cub 1 □ Yes 2 ☑ No	dispanic Origin? (S an, Mexican, Puert Specify:	pecity resion No o Rican, etc.)		14. Race - Black, \ Specify:	American White, etc Whi	
ted		15. Decedent's	s Education		6a. Deced	dent's Usual Occup	pation		16b. Kir	nd of Busin	ness/Indus	stry
Completed	Elementary/Se		grade completed) College (1-4or	5+)	life. L	DO NOT use retire	during most of word)	king	Eye	Glass	s	
S	12				Mai	ntenance				Manufa	actu	rer
Be		e (First, Middle, L					18. Mother's Nan		Maiden :	Surname)		
은	Clyde C.						Evelyn					
		Name/Relationshi				,	and Number or Ru					
. :	20a. Method of D	Sanner/V	viie			rriends esition (Name of	ville Rd.	, Friend		LIE, I cation - Cit		21531 n. State
	1 X Burial	2 ☐ Cremation ;	3 🗋 Removal from State	ceme	etery, cren	natory or other pla					•	
		n 5 □Other (Sp. Fµmeral Service L		B100	_		netery Ma					
		an 1	eigneu))	1		140				-	
To Be Comple	Immediate Cardisease or condi resulting in death	r he disease, o c dart failure. List o e (Final tion 1)	complications that cause only one cause on each li		Do not ent	er the mode of dyi	275, Grang, such as cardiac	or respiratory a	rrest,		Jr.	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 05/16/2009 1645 p Patricia Ann Saulter-Sowell /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert. If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 1 F 70 Director 184-30-4593 04/04/1939 PA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show Examiner must be notified at 1 ☐ Yes 2 No MD Calvert Director Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 "natural", or items 23a 423 McMichael's Drive 20657 U.S.A. 14. Race - American Indian, Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Book Keeper Security 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clyde E. Simmers Grace E. Smith 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Saulter/Son 423 McMichael's Drive, Lusby, MD 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of h Important: If Ite any Injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans 4 ☐ Donation 5 ☐ Other (Specify) 05/26/2009 Cheltenham, MD 21. Signature A Funeral Service 12 nsee 22. Name and Address of Facility Lee Funeral Home, Calvert P.A. Lisa M. Mounts \$125 Southern Md Blvd., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIAC ARYTUMIA **Physician** disease or condition resulting in death) /Medical Pulmoner discort Examiner Chronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) Renal The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy **a**⊿No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) 1 Natural To the nucephase within 24 hours after death. To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Name of the cause (s) and manner as stated. Medical

Division or Vital Records, P.O. Box 68760.

Jew) 5

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only one)

20060638

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 5/18/09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 110 HOSPITAL 20678 MD FRE DERIUL

PRINCE 32. Registrar Signature

Merolono

WAY20 back 2009

Registrar

well George Sa		on St 1- For State	ate of Maryla		Depa		t of I	Health		Menta	l Hyg		- N-	200	10 179	2
Physicia ledical Examir	n/	Registrar 1. Decedent's Name (First, Midd Lowell George	e,Last) Salmon									Date of Death Month May 22, 20	Day Y	ear	3. Time of Death 1900 hrs	Í
		4a. Facility Name (if not institution 1701 Cattail Common	-	imber)			- 1	. City, Tov Denton	n, or Lo	cation of [,	4c. Count Carolin			1
Funeral Director		5. Social Security Number 196-30-8919	6. Sex	7. Age (st birthda	yrs.	If Under	Year Days	If Under 2 Hours	24Hrs. Min.	8. Date of Birt	,	Foreign	nplace (State or n ntryPennsylvania	
any		Usual Residence of Decedent 10a. State 10b. County	I A M Z F	I10		Town or I	1					11/14/	1750		10d. Inside City Limits	-
	į	Maryland Caroli	ine		Dent								1 X Yes 2 No			
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 1701 Cattail C			10f. Zip C 21	629			10	10g. Citizen of What Country? USA						
r death w	11. Mantal Status 1 Never Married 2 X Married 1 Never Married 2 X Married 1 X Yes 2 No								Was Decedent of Hispanic Origin? (Specify Yes or No- lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)					nite, etc.	an Indian, Black,	
2 hours aft "natural"	widowed 4 Divorced if res. 1959–1961 1 Yes 2 k No spectry:											Specify 16b. Kind of			1	
MD 21215-0036 d 2 should be filed within 72 hours th and Mental Hygiene. n 27 is marked other than "natur aumatic event, the Medical Exam	Completed	17. Father's Name (First, Middle	5.			Highe	r Ed	ucatio					MD. High Maiden Surmar		ıc. Commission	1
\$ 5 E 5	To Be	Ray J. Salmon 19a. Informant's Name/Relations	ship (Type, Print)			19b. N	Mailing A	Address		Ruth			nber, City or To	own, State,	Zip Code)	
		Joan A. Dove /	Wife			Place of D	isposití	on (Name				ay, Der Date	ton, M		and 21629 Town, State	-
Baltimore, permit. Pages I an Department of He Important: If ite		1 Burial 2 X Cremation 4 Donation 5 Other S	pecify:	om State	Ka1		rema	atory				5-09			Maryland	
Baltimo permit. Page Department o Important: injury or oth		21. Sign lure of Funeral Survey	1			i	297:	3 So1	omoi	ns Is	:lan	d Rd.,	Edgewa	iter,	al Home MD. 21037	
Physician /Medical xaminer	4	23a. Pa 1. Enter the disease, or furre. List only one cause immediate Cause (Final disease or condition resulting in death)	on each line.	erel	bra1	hem			dying, su	uch as car	diac or r	espiratory arr	est, shock, or	heart	Approximate Interval Between Onset and Death	-
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b	conseq	uence of	f):										+
executed an and at - transit	I Examiner	(Lisease of injury that initiated events resulting in death) Last	Due to (or as a			,				4						
rial rial	ledical	XUNPENDED	AMENDED 23c. If yes,				, gt	392 6	7297	709 T	T		23d Date	of deliver		-
Box 68760 e death certificate b the attending physical for use as the bu		23b. Was decedent pregnant in to past 12 months?	he 1 Live	oirth nant at tii	me of de	2		il death er (Specif	-	Ectopic	oregnan	су	Month		Day Year	
P.O. es that the igned by	<u>ج</u>	Part II. Other significant condi	tions contributing t	o death t	but not re	esulting in	the un	derlying c	ause giv	en in Part	t.				the cause of death?	
of Vital Records, P.C ng Physician: The law requires that After this certificate has been signed be	Completed											24a. Was autop perfo	osy rmed?		topsy findings available completion of cause of	
Vital Rec hysician: The this certificate	Be	25. Was case referred to medical examiner?	Hospital:	Inpatient	1 2	ER/Outp	atient		10	f Death (C		Home 5	Residence	6 ✔ Othe	r: Scene	7
E ii ii di	tion: To	1 ✓ Yes 2 No 27. Manner of Death 1 X Natural 5 Pen	ding		, -	28b. Tim		ury 28	c. Injury	at Work?	12		how injury occ			1
Division oital or Attendi urs after death. ral Director: /	Certification:	3 Suicide 6 Cou	estigation Id not be remined (Specify,		ry - At ho	ome, farm	, street	, factory, o	ffice bui	ilding, etc.	1	28f. Location (or Town, \$		mber or Ru	ral Route Number, City	
D To the Hospital within 24 hours: To the Funeral completely filled	Medical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the be miner:On the basis and manner:	of exami	knowledg	ge, death nd/or inve	occurre	ed at the ti	me, date pinion, e	e and plac death occu	e, and durred at	lue to the caus the time, date	se(s) and man and place, ar	ner as stat id due to th	ed. ne cause(s)	
F » F »	Me	29b. Signature and title of certific		statou.	•				icense D.C.M				29d. Date s May 23,		nth, Day, Year)	
		30. Name and a dress of persor Margarita Korell MD.	who completed cau Assistant Me			,	11 Pe	nn Stre	et, Bal	Itimore.	MD 2	1201				٦
Sta Regist	_	31. Date filed (Month, Day, Year)			s Signar		ar			,						

Baltimore, Maryland 21215-0036 Health and Menta em 27 is marked

and P.O. Box 68760. Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 **Physician** May 18, 8:37 A M C. Mary Taylor /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Tate Hospice House Anne Arundel Linthicum 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 1 ☐ M 2 😾 F Months Days Hours 052-30-9461 74 Feb 5, 1935 New York Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland leatth and Mental Hygiene. m 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location other traumatic event, the Medical Examinar must be notified at MD Prince George's Greenbelt 1 X Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22 Ridge Road #116 20770 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 __Yes __ZYNo If Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 📉 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Carrano Sally Margaret Lanzetta ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynda Taylor Reynolds/daughter P.O. Box 130 Maryland Line, MD 21104 permit. Pages 1 a
Department of He
Important: If item
any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) W. Arundel Crematory 05/19/2009 Odenton, MD 21. Signature of Funeral Service License Going Home Cremation Service P.O. Box Beverly L. Heckrotte, P.A. Clarksville, 784 , MD 21029 Devely MO1251 L.He 23a. Part 1. Enter the deease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cancer of Colon /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physiciar Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month Year Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 1 No 2 🗆 No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: ${}_{4\,\square}$ Nursing Home ${}_{5\,\square}$ Residence ${}_{6}X$ Other (Specify) hospice 1 ∐ Yes 2 ∐XÎNo Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Chia D23743 May 19, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7525 Greenway Center Dr. Suite 205 Greenbelt, MD 20770 Martin D. Weltz, D.O. 31. Date filed (Month, Day 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** 19, 2009 4:46 PM May Grace May VanSickle
4a Fecility Name (If not institution, give street and number) /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany The Country House Cumberland 8. Date of Birth (Month, Dey, Yea Dec. 5, 1 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Devs Hours 1 □ M 2 🕅 F Yrs. 86 Dec. 1922 Maryland Director 214-32-3617 Usuel Residence of Decedent Peges 1 end 2 should be filed within 72 hours efter death with the Maryland nent of Heatth end Mental Hygiene. Int: If Itam 27 is merkad other than "natural", or itams 23a or 28a-f show 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location or items 23a or 28a-f show 1 ☐ Yes 2 🖾 No Director Friendsville Garrett 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21531 USA 797 Noah Frazee Rd. Funeral 14 Bace - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: à 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Grocery Store Owner/operator 8 7 is marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be Edith Trimbley Alfred Friend 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt of Health e : if itam 27 is or other tra P.O. Box 148, Friendsville, MD Raymond C. VanSickle/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of important: if any injury or Blooming Rose Cemetery May 22,2009 Friendsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licensee P.O. Box 275, Grantsville, MD 21536 Im acc 0 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of hear tailure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical condinusular disease Examiner Due to (or as a consequence of) Examiner or Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 Unknown 1 ☐ Yes 2 ☐ No Š 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Be Completed 2 X Nu 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 4 ☐ Nursing Home 5 KResidence 6 ☐ Other (Specify) 1 Yes 2 No To the Hospital or Attanding Physi-within 24 hours efter death. To the Funeral Diractor: After this c completely filled in by the funerel dir Medical Certification: To 2 ER/Outpetient 3 DOA this 27. Menner of Death 28c. Injury et Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 Tyes 2 No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as seaso.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 2009 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Bishop Walsh 7 925 WONSOCK 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 1 - State Registrar 5-22-09Amend#17.PerFHPGCcr Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5/19/2009 **Physician** Mildred Elizabeth Vanaman 11:45 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🔀 F **Director** 578-26-6926 84 10/16/1924 Washington, DC Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1⊠Yes 2□No Director MD Prince George's Hyattsville 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 5805 42nd Avenue, #221 20781 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural" or items 23 any Injury or other traumatic event, the Modical Examiner must any Injury or other traumatic event, the Modical Examiner must penes. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No þ Specify: 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)
Manve Be Arthur John Manuell Mathilda Wealland ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Edwards / Nephew 2313 Fairview Terrace, Alexandria, VA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 5/22/2009 Metropolitan Crematory |Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21, Signature of Funeral Service Licensee 4739 Baltimore Avenue Gasch's Funeral Home, PA Hyattsville, MD 20781 man 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Lines underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physiclan: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? C80 24a. Was an autopsy performed? 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 ☑ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑1npatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of al or Attending P after death. I Director: After t d in by the funera 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

31. Date filed (Month, Day, Year) Registrar

29b. Signature and title of certifier

CO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CCA

fex

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death WATERS Year 8-14 M **Physician** KAYNOR 2009 (JEORGE Tru /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NICOMICO 59013641 POIMS Centu KegOWAL If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Days Hours 1**№** M 2□ F MARYLAND 37 24-34-7241 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County 10a. State show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Invoice Examinar must be notified at 1⊠Yes 2 No Saliebure Director Wicomico MARYLAND 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number Church USA 21804 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, Black, White, etc, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ∐Yes 2 ⊠ If Yes, Give Year or Dates: hours after 1 □ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: BACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) within 72 and 2 should be filed within ealth and Mental Hygiene.

7 27 Is marked other than, Elementary/Secondary (0-12) College (1-4or 5+) LABORER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MAYD BARKIEH WATERS JAMES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Church Health em 27 I HELEN WATERS 818 E Md 21804 Department of Healt Important: If item 2 any injury or other once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other) Date Pages 1 ment of H 20a. Method of Disposition 1⊠ Burial 2 ☐ Cremation 3 Removal from State 5-20-09 MARGLAND Sprinah 4 Donation 5 Other (Specify) 22. Name and Address Facility 21. Signature of Funeral Service is nsee Home 821 SteWOR TUNERAL Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Decidonoru) disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter U. Jerrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner signed by the attending physician and be detached for use as the burial-transi Due to (or as a consequence of): P.O. Box 68760, The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. $\mathcal{M}_{\mathcal{L}(\mathcal{M}_{\mathcal{L}})}$ ε Division of Vital Records, Completed by anemia 2 No 3 Probably 4 Unknown has been signed to the property of the propert 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ntw 24a. Was an page 2 s autopsy perform 1 □Yes 2 ☑ No anasraeams After this certificate or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No filled in by the fu investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I Hospital Medical 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of 7/09 1450497 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 59/1364M 100 E. CAMO!

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month.

Year

19

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Janet Lorraine Wilkerson MAY 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Joseph Medical Baltimore Saint Center Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | June 8, 1925 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🗓 F Maryland 212-20-8890 83 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Il Medical Exp. is at ...ust be rutified at 1 ☐ Yes 2 X No Director Parkton Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20112 Cameron Mill Road 21120 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 M Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: ۶ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Medical Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Bailey Charles Stevens ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20112 Cameron Mill Rd., Parkton, MD 21120 Raymond L. Wilkerson, Sr./Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cremation
Direct Service 20a. Method of Disposition
1 ☐ Burial 2 🛣 Cremation 3 🛣 Removal from State 20c. Location - City or Town, State May 30 York, PA 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) CARDID-RESPIRATORY ARREST /Medical Due to (or as a consequence of) Examiner SEPTIC SHOCK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical RENAL FAILURE IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 D No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year signed by the a 5 Other (specify) P.O. 1 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ð 2 No 3 Probably 4 Unknown 1 □ Yes Completed ACUTE MYOCARDIAL INFARCTION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was ar cate has b page 2 st LACTIC ACIDOSIS autopsy performer this certificate 2 No 2 100 1 □Yes 1 Tes the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 nous after death.

neral Director; After this filled in by the funeral di 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division (Month, Day, Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide e Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 hour To the Funer completely file 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MY 5-26-09 ·cueus D31826 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature OSLER DRIVE TOWSON, MARYLAND 21204 State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene For Stata Registra Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** May 2009 10:45 P M Helen R. 13 Winters /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Dennett Road Manor Nursing Home 0akland Garrett If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🖫 F Yrs. Director 366-28-8032 87 1921 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or items 23s or 28s-f show other traumatic event, the Modical Examinar must be notified at 1 Yes 2X No Director Garrett Swanton 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 39 Fox Hollow Road 21561 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed by 3 X Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home f Health and Mental Hygid Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be ၉ Charles Milford Glass Jennie 0. Helmick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Sweitzer, Daughter 2507 Swanton Rd., Swanton, MD 21561 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition jo = 1 Burial 2 □ Cremation 3 □ Removal from State Department of 5/16/2009 4 ☐ Donation 5 ☐ Other (Specify) George Cemetery Swanton, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility David A. Burdock Funeral Home, P.A. 21 N. Second St., Oakland, MD 21550 Catherine Suringer 23a. Part1. Enter the disease, or complications that flused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner brillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) the detached 9□ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed been 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an After this certificete has funeral director, page 2 s autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 700 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident the within 24 hours after deat To the Funeral Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a le title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 219.50 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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/Medi		Karen Rann 4a. Facility Name (If not institution, give		son	4h City Town o	or Location of Death	MAY	4c. County	of Death
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- Farmanal		Baltimore Wash 5. Social Security Number 6. S		yrs. last birthday)		If Under 24 Hrs.	8. Date of Birt		9. Birthplace (State or Foreign
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Mariter IF a miner must be notified at angues.	/ Funeral	11. Marital Status 1 □ Never Married 2 🛣 Married	Armed Forces? 1 Yes 2 No If Yes, Give		if Yes, specify Cub 1 □Yes 2 🛣 No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Black	k, White, etc.
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Baltimore, permit. Pages 1 ar Department of Hee mportant: If item any injury or othe once.		20a. Method of Disposition 1 Burial 2 Cremation 3 C	Removal from State		sition (Name of natory or other pla	ice)	Date	Cheste	City or Town, State rtownmd own, Mb
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/Medical		disease or condition resulting in death)	a. Due to (or as a cor	nsequence of):	1110	40707			- 37
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Box 68760, eath certificate be executed attending physician and for use as the burial-transit	₩.	IF FEMALE:	23c. If yes, outcome of pr	egnancy				22d Da	te of delivery
of Vital Records, P.O. Box 687 Phystclan: The law requires that the death certificate this certificate has been signed by the attending physical director, page 2 should be detached for use as the	Completed by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live birth 2 4 Pregnant at time 9 Unknown	Fetal death 3	☐ Ectopic pregnan ☐ Other <i>(specify)</i>	су			onth Day Year
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I Records, P.O. The law requires that the date has been signed by the page 2 should be detached	dmo						auto	psy ormed?	prior to completion of cause of death? 1 □ Yes 2 □ No
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To the h within 24 complet	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. Licen	nse number		29d. Date signe	ed (Month, Day, Year)
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		17 Egner	ul, no	(1) 00 \ (7)	Dec	59190		MAY	0, 2009
3		30. Name and address of person who	completed cause of death	(item 23a) (lype,	Print)	00:	N .2		URMIE MD 201
	ate	31. Date filed (Month, Day, Year)	32. Redistrar's S	Signature .	301 (40	15/11/1	DK.	ILEN IS	10/10/10 -140 20
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DHMH 17 Rev 1/2001

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CERTIFICATE #

* total * 2009-00759

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Month Day 13 heisha 2009 11a7 4c. County of Death Facility Name (If not Institution, give street and number, 4b. City, Town, or Location of Death **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 989 Days 20 Delaware 222-76-1108 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No Houston De. Kent 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 19954 2119 Hunter Quarter Road USA 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify. 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Cashier Mc Donalds 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Worthy George Johnson Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Father 2119 Hunter Quarter Rd., Houston, De. 19954 George Johnson / 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Milford Community Cem. 1 Burial 2 Cremation 3 Removal from 05-23-09 Milford, Delaware 4 Donation 5 Other (Specify) 21. Signature of Funeral Sovice Licenses 22. Name and Address of Facility Bennie Smith Funeral Home 274 Rehoboth Blvd., Milford, De. 19963 Approximate Interval Between Onset and Death aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease shock, or heart failure. List only one cause or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of)

Physician /Medical **Examiner**

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10a. State

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29b. Signature and title of certified

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Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

physician ar ģ eral Director: Af filled in by the fu

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 1 ✓ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 V Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery Month Day Year MAY 13 2009								
Part II. Other significant condition	s contributing to death but not resulting in the underlying cause given in Part I. His, acute renal failure	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown								
	·	24a. Was an autopsy autopsy performed?/ 1 □ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No								
25. Was case referred to medical	26. Place of Death (Check only one)									
examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 Residence 6 Other (Specify)								
27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28c	Describe how injury occurred								
3 Suicide 6 Could no 4 Homicide determin		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	Physician: To the best of my knowledge, death occurred at the time, date and place, and									

29c. License number

Res-000

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

14,2009

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and P.O. Box 68760. Division of Vital Records.

1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Harry Bowles 2ďď9 Jüne 10:35 aM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Balt., County Randallstown Northwest Hospice If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 58 Director 216-56-9149 12-25-50 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show Funeral Director MD N/A Baltimore 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21244 1906 Calais Ct. USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give 1070 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status other traumatic event, the Medical Examiner Specifican 1 Never Married 2 Married 6 1 □Yes 2√√ No Be Completed by ii res, Give Year or Dates: 1970-72 3 ☐ Widowed 4 ☐ Divorced and Mental Hygiene. Is marked other than "natural", American 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bakery Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harry Ross Catherine Bowles 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any injury or other trau Carolyn White/Sister 3312 Lawnview, Balt., MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/11/09 Owings Mills, MD Garrison ForestVA 4 ☐ Donation 5 ☐ Other (Specify) ^{22.} Name and Address of Facility Hari P. Close F. Svs. PA 5126 Belair Rd, Balt., MD 21206-5105 21. Signature of Funeral/Service Ligensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final hysician 5 DAUS b ne u monia disease or condition resulting in death) /Medical Due to (or a a consequence of): xaminer ence mode pathy anoxic 2 months Sequentially list conditions, if any, baung to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed relieve accident 27 years Motor Due to (or as a consequence of) Ly partensie in Physician/Medical 1044 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Diohetes mellitus Chronic 1 Yes 2 No 3 Probably 4 Unknown Be Completed on Homodialysis 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an performed? 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) N. W HUSDIA 1 Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending Auto acciden 2 Accident investigation unknown unknown 1 ☐ Yes 2 No after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide UNKNOWN 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 614/2009 * DESHIND D30494 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) maiden charcelone calensville maryland 21228 716 K. DESAIND 32. Begistrar's Signature 31. Date filed (Month; Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. FoAmend Item 29d State of Manual Hygiene State Registrar 2. Date of Death Depedent's Name (First, Middle, Last) Month Physician 3:20 M HOULY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Gity, Town, or Location of Death Examiner HIMOT If Under 1 Yea 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Age (In yrs. last birthday **Funeral** Days Months 1 □ M Yrs. **Director** Usual Residence of Deceden 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination and the confined at once. 1 Yes 2 □ No MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 22 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 2 No 1 ☐ Yes Specify. \$ Specify. 3 Widowed 4 Divorced HOIGEK Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be -uneur 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Burch Brother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** normon /Medical Due to (or as a consequence of) **Examiner** SGASC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a nonsequence of) Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 ☐ Yes 2 ☑ No 2 X No 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 To other Specify HOSP (CE Hospital: 2 No P 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital or within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

JUN 0 4 2009 There A back

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835

Smith Ave Suile 203 Baltimore MD 21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Physician 10:08 PM 2009 Mary Bly Barbehenn Ma /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death St. Agnes Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□ M 2 F Months Days Hours Director 6/9/40 Maryland 218-36-9143 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Director Md Howard Elkridge 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6704 Foxcathcher Court 21075 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Honevwell 12 Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cha<u>rles Wilmer Santmyer</u> 2 Mary Christina Brehm 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. George Barbehenn / Husband 6704 Foxcatcher Court Elkridge, Maryland 21075 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Baltimore Crematory 6/3/09 Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave. Baltimore, maryland 21229 23a. Part1. Enter the disease, or shock, or heart failure. Live implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final disease or condition resulting in death) Renal -Je iunal Fistula **Physician** /Medical Examiner 1 moath Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, p. ge 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 ☑ No 2 **(**No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

To the To the To the

Sarbehenn, Mar

State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21229

Caton Avenue

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gerard De Castro

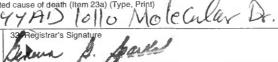
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31. Date filed (Month, Day, Year)

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State Registrar 31. Date filed (Month, Day, Year) -

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



09-04235 UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 17843

		1- For State Certificate	of Death		Re	2 U U	J 1707
Physic		Decedent's Name (First, Middle,Last)			Date of Deat Month	Day Year	3. Time of Death 2330 hrs
edical Exam	ıner	COKIID BROWN	I de Oite Terre en l	Leasting of Dooth	May 27, 20	4c. County of Death	2330 1118
		Facility Name (if not institution, give street and number) 1101 W. North Avenue	4b. City, Town, or I Baltimore	Location of Death		N/A	
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)		If Under 24Hrs	. 8. Date of Bir		hplace (State or
Director		213-90-2377 XX M 2 F 32 Usual Residence of Decedent	Yrs. Months Days		_	Foreig	MARYLAND
áu.		10a. State 10b. County 10c. City, Town or L	ocation				10d. Inside City Limits
nd frow a	L	MARYLAND N/A	BALTIMORE				1 XXYes 2 No
arylar 8a-fs at on	Director	10e. Street and Number	10f. Zip Code		11	0g. Citizen of What Cour	try?
the M a or 2 tiffed	ä	2212 McCULLOH STREET	2121	L 7		U.S.A.	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tant: Filen 27 is marked other than "natural", or items 23a or 28a-f show any or other transmatic event, the Medical Examinez must be notified at once.	Funeral	1 X Never Married 2 Married Armed Forces?	3. Was Decedent of His If Yes, specify Cuban			- 14. Race - Ameri White, etc.	can Indian, Black,
er des ', or i	3	1 Yes 2XX No 3 Widowed 4 Divorced If Yes, Give Year	Yes 2 X No	specify:		Specify: BI	LACK
urs aft tural' tmine	호	or Dates:	edent's Usual Occupati		work done	16b. Kind of Business/l	
72 hou	etec	Elementary/Secondary (0-12) College (1-4 or 5+)	ng most of working life.	DO NOT use ret	red)		
036 rithin rese. r that	Completed	11th grade FO	ORK LIFT DE	RIVER		PRIVAT	?E
ID 21215-003 should be filed within and Mental Hygiene.	ပိ	17. Father's Name (First, Middle, Last)		18.Mother's Name	e (First, Middle, I	Maiden Surname)	
121 d be f fental narker	o Be	CURTIS L. BROWN SR. 19a. Informant's Name/Relationship (Type, Print) 19b. M	Isilia a Addasas (Oliver		ERINE PA	ARKER hber, City or Town, State	Zin Cada)
Shoul and A	ř		•			e, Maryland 2	
ore, M es 1 and 2 of Health If item 2 ther traum		20a. Method of Disposition 20b. Place of Di	isposition (Name of cen		Date	20c. Location - City or	
10r ages 1 nt of 1 t: If		1222 bullar 2 Oremation 3 Nemova nom State	or other place)		0.4.00	DATETIONE	MADAL AND
Baltimore, MD 21215-0036 permit Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medica			EMORIAL PAR 22 Name and Address		-04-09	BALTIMORE, FUNERAL HO	
The Dept.	(1 / W / Du (. /)	1206 W NOF	RTH AVEN	JE		OME P.A.
Physician		Part I. Enter the disease, of complications that caused the death. Do not er failure. List only one cause on each line.	nter the mode of dying,	such as cardiac o	or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and
/Medical xaminer		Immediate Cause (Final dis ase a. Gunshot Wound of Neck					Death
		or condition resulting in death) Due to (or as a consequence of):					
	iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlyin, Cause					
ted I insit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):					
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x 68 h certiff tending use as	Physician	past 12 months? 4 Pregnant at time of death	Fetal death 3 Other (Specify)	Ectopic pregna	апсу	World	Jay Teal
Box (e death or the attenued for use	hysi	1 Yes 2 No 9 Unknown g Unknown					
Division of Vital Records, P.O. Box 681 pital or Attending Physician: The law requires that the death certificate after death. After this certificate has been signed by the attending filled in by the funeral director, page 2 should be detached for use as!	þ	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause g	jiven in Part I.		obacco use contribute to s 2 ✓ No 3 Prot	
of Vital Records, ng Physician: The law require. The this certificate has been as meral director, page 2 should t	Completed	4			24a. Was		topsy findings available
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of of ng Ph	-	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time		ry at Work?	28d Describe Subject sho	how injury occurred	
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Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,	street, factory, office b	ouilding, etc.		Street and Number or Ru State) orth Avenue, Baltimor	
Dospita hours ineral y fille		4 Homicide determined (Specify) Parking Lot					
To the Hospital within 24 hours To the Funeral completely fille	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation	occurred at the time, da stigation, in my opinion	ate and place, and , death occurred	d due to the cau: at the time, date	se(s) and manner as stat and place, and due to th	ed. e cause(s)
To with To com	Mec	and manner stated. 29b. Signature and title of certifier	29c. Licens			29d. Date signed (Mo	
		and -	O.C.I	M.E.		May 28, 2009	
2		30. Name and address of person who completed cause of death (Item 23a)	L			<u> </u>	
21			nn Street, Baltimo	ore, MD 2120	1		
S	tate	31. Date filed (Month, Day Year) 4 2009 32. Figistrar's Signature	barles				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Krown D5 HNN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NIA Ballimore Windsor Birthplace (State or Foreign Country) Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 05-07-5 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 2**Z** F Min. Months Hours 214-58-716 Usual Residence of Decedent MD Director 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State "natural", or items 23a or 28a-f show traumatic event, the Medical Evandrant nust be notified at 1 Yes 2 □ No **Funeral Director** Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Completed by Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, tow My any injury or other traumatic event, tow My any injury or other traumatic event, tow My any injury or other traumatic event, tow My any injury or other traumatic event, tow My any injury or other traumatic event, tow My any injury or other traumatic event, tow My any injury or other traumatic event, tow My any injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) 12 grade

17. Father's Name (First, Middle, Last) Social 18. Mother's Name (First, Middle, Maiden Surname) Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randalstown, MD 21133 R. Brown. 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 20b. Place of Disposition (Name of cemetery, crematory or other p 3 Removal from State Baltimore MD C. Greenefteneral Sign 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Myelong inle /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): attending physician for use as the buria Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 009 Minnie /Medical Barnes 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Randallstown 5. Social Security Number S1-6-6 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 6. Sex Funeral Months Days Hours Min. 1 □ M 2 🗷 F 218.80.7376 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show r than "natural", or items 23a or 28a-f shov the Madical Examiner must be notified at 1 □Yes 2 No Ba ltimore Baltimore Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3503 Essex 21207 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the the by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11, Marital Status 1 Never Married 2 Married 1 □Yes 2 XNo Specify. Specify: Black 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hudains Eliza Wright ပ 19b. Mailing Address (Street and Number or Rural Ro Jumber, City or Town, State, Zip Code) 19a. Informant's Name/Rela ship (Type. Print) 3503 Essex Road Baltimore MD 21207 Husband 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, MD gamison Forest 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Vaux Randallstown, MD 21133 23a. Part 1. Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hearthailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Aspinches PRUVINGAL /Medical Due to (or as a consequence of): Examiner MOUVER Dement Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burtansit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22No 1 ☐ Yes 2 Z No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\subseteq\) Nursing Home \(5 \subseteq\) Residence \(6 \subseteq\)Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D290 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Pastrar's Signature State

Registrar

			For State Registrar	State of Ma	arylan		artmen rtificate			and Me	_	giene Reg. No	7111	9	178	46
			1. Decedent's Name (First, Middle, Las	st)						2	2. Date of De Month	ath Dav	v Ye	ar -	3. Time of De	eath
	Physici /Medic		MATHEM	И В.	CAF	FREY					May	26,	2009		10:50 A	М
	Examin	er	4a. Facility Name (If not institution, given 1107 Battery Av				E	altin					County of E	A		
	Funeral Director		5. Social Security Number 6. S 067–22–6075	ex 7. Ag	e (In yrs. 82	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da October	th av. <i>Year)</i> 8, 19	9. 126 N	Birthpla Counti Vew Y	ace (State or F ry) Ork	Foreign
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10	d. Inside City I	Limits
	the Marylar 28a-f show notified at	to	Maryland N/A			-	imore								1 XYes 2	□No
	with the 3a or 28a t be notif	I Director	10e. Street and Number 1107 Battery Avenue		1		10f. Zip		.230			10g. Cit	izen of Wha		ry?	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Moderl Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 MYes 2 If If Yes, Give Year or Dates:			Was Deced If Yes, spec	1.5	ispanic Ori n, Mexicar Specify:		cify Yes or No lican, etc.))-	14. Race - A Black, V Specify:		c.	
Baltimore, Maryland 21215-0036	hin 72 ho e. an "natur Molen	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4or 5	5+)	16a. Dece (Give life.	dent's Usua kind of wor DO NOT us	l Occupa k done d se retired	ation during mos)	t of working	g		ind of Busin			
2	ed wit ygien ier th	Con	12	6		Adn	ministr	ator					1 Labor	ator	ies	
land	uld be file Aental H rked oth tic even	To Be	17. Father's Name (First, Middle, Last) Bernard Caff							er's Name (Ell en	(First, Middle Me	, Maiden Gee	Surname)			
Mary	nd 2 shou Ith and N 27 is ma	-	19a. Informant's Name/Relationship (Bernadette N. Caffer								Route Numb				Code)	
ē,	s 1 and 1 Hear item other		20a. Method of Disposition		20b. F	Place of Dispo	sition (Nan	ne of	1	Da	-		ocation - Cit		vn, State	
Ë	Page nent o int: If		1 Burial 2 Cremation 3 C 4 Donation 5 Other (Specif		Hol	y Cross	Cemete	ry	N	∕ay 30,	, 2009	Brook	olyn Par	ck,Ma	ryland	
Balt	permit. Departr Imports any inji		21. Signature of Fune al Service Lice	Hann	h	M.	Name an Cully- 30 East	d Addres Polyr Fort	s of Facilities Fu niak Fu Avenu	ineral ie, Bal	Home P. Ltimore,	A. Mary	land 2	1230		
	Physician	a	23a Part 1. Enter the disease, or com- shock, or heart failure. List only immediate Cause (Final disease or condition	plications that caused one cause on each li	the deat		ter the mod	e of dyin		cardiac or					Approximate Interval Betwe Onset and Dea	en ath
7	/Medical Examiner		resulting in death)	Due to (or as	a conseq	juence of):										
بهي	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a conseq	uence of):										
8760, N	cate be executed physician and the burial-transit															
9	leath certifica attending ph for use as th	/Med	IF FEMALE:	23c. If yes, outcome	of pregn	ancv							02d Date o	f dollars	Ps	
.0. Box	or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Ē No 9 ☐ Unknown	1 Live birth 4 Pregnant a	2 Feta	al death 3	☐ Ectopic p ☐ Other (sp		у				23d. Date o Month		Day Ye	ar
rds, P.	law requires that the deas been signed by the 2 should be detached	þ	Part II. Other significant conditions of	contributing to death b	out not res	sulting in the u	nderlying c	ause give	en in Part I		23e. Did		4	ite to the	e cause of dea ably 4 ☐ Uni	
Division of Vital Records,	'he law requ te has been age 2 should	Completed										psy ormed?	prio	r to con	osy findings av	ailable use of
ta	ician: The certificate ector, pag	Be C	25. Was case referred to medical						26. Place	e of Death	1 ☐ Yes (Check only	2 No) 1	Yes	2 AINO	
>	Physici this ce al direc		examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpati	ent 2] ER/Outpatie	nt 3 🗆 DC	Oth	er: 4□N	ursing Hom	ne 5 Res	idence	6 □Other	(Specify)	
o uo	ding Pt th. : After the funeral	tion:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inji (Month, Da	ury ay, Year)	28b. Time o Injury	of 2	8c. Injur Worl	yat <br Yes 2□		8d. Describe	how inju	ry occurred			
Divis	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Certification: To	3 Suicide 6 Could not be determined		ury - At h c. <i>(Speci</i>	ome, farm, sti ify)	reet, factory	, office		2	8f. Location (City or To	(Street a wn, Stat	nd Number e)	or Rurai	Route Numbe	er,
	the Hospital of thin 24 hours a the Funeral Completely filled is	Medical C		nysician: To the best miner: On the basis of and manner st	of examina											
	To the Compl	Me	29b. Signature and title of certifier				290	c. Licens	e number				ate signed (_	
	atl		b totale. De	ut fr	Nooth /la	m (20) /T:	D. J. D.		ilel			M	ey 26	2, 2	700	
	10,		30. Name and address of person who Robert C Rust	100 . 2.	E.	Fort	tue.	ho	ultin	wre	M	0	217	-3	<u>ي</u>	
	Sta Registr		31. Date filed (Month, Day, Year)	Regist	ars Signa	ature A	00.0									

Physician / Medical Examiner ANITA R. CAPLAN 4a. Facility Name (If not institution, give street and number) SEASON'S HOSPICE Funeral Director 5. Social Security Number 6. Sex 1 A A Security Number 1 A A Security Number 1 A A Security Number 1 A A Security Number 1 A A Security Number 1 A A Security Number 2 A A A A A A A A A A A A A A A A A A	N 8. Date of Birth (Month, Day, W. JUNE 18,	Day Year 2009 4c. County of Death BALTIMORE 9. Birthplace (State or Foreign County) MARYLAND 10d. Inside City Limits						
ANTIA R. CAPLAN 4a. Facility Name (If not institution, give street and number) SEASON'S HOSPICE Funeral Director 5. Social Security Number 216-34-5862 ANTIA R. CAPLAN 4b. City, Town, or Location of RANDALL STOW RANDALL STOW 1 Under 1 Year If Under 2 Months Days Hours 7. Age (In yrs. last birthday) Antia R. CAPLAN 4b. City, Town, or Location of RANDALL STOW RANDALL STOW Months Days Hours	N 8. Date of Birth (Month, Day, W. JUNE 18,	9. Birthplace (State or Foreign Country) MARYLAND						
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		10d. Inside City Limits						
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MD BALTIMORE REISTERSTOWN 106. Street and Number 405 VALLEY MEADOW COLLET #A4 21136		1 □Yes 2 No						
10f. Zip Code 405 VALLEY MEADOW COURT #A4 21136	10g.	. Citizen of What Country?						
4 82 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8	in? (Specify Ye's or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.						
1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify:		Specify: WHITE						
15. Decedent's Education (Give kind of work done during most	tact 16	b. Kind of Business/Industry						
10a. State 10b. County BALTIMORE 10c. City, Town or Location REISTERSTOWN 10f. Zip Code 405 VALLEY MEADOW COURT #A4 11. Marital Status 1	jälist S	OPTOMETRY						
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Tob. County MD BALTIMORE 10c. City, Town or Location REISTERSTOWN 10c. Street and Number 405 VALLEY MEADOW COURT #A4 11. Marital Status 10c. Street and Number 405 VALLEY MEADOW COURT #A4 11. Marital Status 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1								
		c. Location - City or Town, State ALTIMORE, MD						
1 M Burial 2 Cremation 3 Removal from State BETH TFICH CUNG. 5 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee. 22. Name and Address of Facility 8900 RFISTERST		ON & BROS., INC.						
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disease or condition resulting in death) disease or condition resulting in death) a. Due to (or as a consequence g9.7)								
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ifficate bergap the buring as								
FEMALE: 23b. Was decedent pregnant in the past 12 mor/fths? 1 Yes 2 No 9 Unknown 2 Unk		23d. Date of delivery Month Day Year						
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23a Did tobas	cco use contribute to the cause of death?						
Signatura in the state of the s		2 □ No 3 □ Probably 4 □ Unknown						
O S S S S S S S S S S S S S S S S S S S	24a. Was an autopsy performer 1 □Yes 2 □	24b. Were autopsy findings available prior to completion of cause of death? ☐ ☐ Yes 2 ☐ No						
E specific s	of Death (Check only one)	TETES ZEINO						
E E E O I Ves 2 1 Ves 2 1 Ves 2 1 Ves 2 Ves 1 Ves 2 V	sing Home 5 Residence							
27. Manne of Death Comparison of Death	28d. Describe how	injury occurred						
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)						
29a. Certifier 29a. Certifier 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one)	d place, and due to the cause h occurred at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)						
29c. License number	29d.	Date signed (Month, Day Year) May 28,2009						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	100	sillo Ma welled						

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 7:59 AM oseph reekmore MA 30 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Columbia Howard HOWARD County GENERAL Hospital 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (În yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Social Security Number **Funeral** Min. Months Days Hours 1 M 2□ F Director Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumetic event, it is Medical Examinat be authored. 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 Yes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No IfYes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Wen commissioned Ô: 18. Mother's Name (First, Middle, Maiden Surname, Be more ၉ Kins 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) HMancla 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Lecation - City or 20a. Method of Disposition Burial 2 Cremation 3 R 21. Signature of Funeral Service Licensee 22. Name and Address of Pacility Approxi te Interval etween Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as pardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Metastatic Prostate Cances disease or condition resulting in death) /Medical Examiner ongestive Heart Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed Mellitu Diabetes attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred To the Hospital or Attending 1 Alatural
2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide TEX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. within 2. 29b. Signature and title of confine 29d. Date signed (Month, Day, Year) 5037 30 2009 GM and address of person who completed cause of death (Item 23a) (Type, Print) Perline Michael 5755 Cedar Ln. MD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year)

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** DWIN BERNARD CAULK 4.11PM 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ltimore 1 Dmanor Kogo 9. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Hours Months Days 1 M 2 □ F 220341668 Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c. City, Town or Location 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinations to notified at 1 Nes 2 No Director mo Saltimore 72 hours after death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 41 Upmanor

11. Marital Status 21229 1000 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cydan, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑ No Specify þ Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I be filed within 7 intal Hygiene. Elementary/Secondary (0-12) Health and Mental Hygiene. College (1-4or 5+) river I ransportat 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) au lic avaa Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship _(Type. Print) Department of Health a Important: If item 27 is any injury or other tra Ba Ho. mD 21229 1 He 41 Uomanor
20b. Place of Disposition (Name of cemetery, crematory or other place) WITE 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Scremation 3 ☐ Removal from State Cremative 6-6-09 woodlawn mi areenmount 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaughon C. Breene Funeral Services 5151 Baltimore, National Pike Balto. MDZRE 21. Signature of Funeral Service Licensee Balto. MDZ1229 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ARDIOVASCULAR DISEASE Physician HYPERTENSIVE SEVERAL disease or condition resulting in death) /Medical Due to or as a consequence of): YEARS Examiner Saquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Year 5 Other (specify) signed by the a 1 ☐Yes 2 ☐ No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ AKDIOMYOPATHO WILL 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? DIAKETES cate has I page 2 s ARUSE, NON COMPLIANCE PER YES ALCOHOL WITH VASCULOPATHY certificate 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) To the Hospita.

within 24 hours after dearn.

To the Funeral Director: After this c 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2009 6 Raw D0018362 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wilkens Ave Ste 40. Baltimore.

DHMH 17 Rev 1/2001

Registrar

3455

Registrar's Signature

K Dang

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 Month **Physician** DICKEN Lmmc 10 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** NA Baltimore & Rehab. N.H. Elizabeth If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 🗹 F SC 220-22-3855 92 11 - 14 - 16**Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State of Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modeal Examiner must be notified at 28a-f show 1 Yes 2 □ No Baltimore Director MD NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21229 Hilton Street 151 S. Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2**▼** No Specify Specify: Black 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Windsor Rest Home Pages 1 and 2 should be filed withinent of Health and Mental Hygiene. Nurses Aid 4th Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anderson Louise Anderson ည 19a. Informant's Name/Relationship (Type. Print)Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau 3142 Leeds Street Baltimore, MD 21229 <u>Dr. Virginia Ferguson</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD Loudon Park Cem. 06-06-09 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Homes P.A. 21. Signature of Funeral Service 638 N. Gilmor Street Baltimore, MD 21217 23a: Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** LDECK disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Clementic Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) I∐Yes 2 ☑No ned by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? certificate has been signed rector, page 2 should be det Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 ☑ No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2∐-No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 24 hours after death. Funeral Director: After the etely filled in by the funeral is 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 ☐ Pending investigation 1 M Natural 1 □Yes 2 ☑No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ca within 24 hor To the Fune completely fi (Check only one)

State

the

DHMH 17 Rev 1/2001

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUN 04

121P

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Goldsberough

3320

29c. License number

12111615

Benson Ave

29d. Date signed (Month, Day, Year)

613109

Baltimore, MD

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 5:35 2009 CHARLES B. DORAN, JR. 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Good Samaritan Hospital Baltimore City 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 1**X**M 2□ F 8. Date of Birth (Month, Day, Mar. 23 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Hours Min. 65 Yrs. Marvland 213-42-3422 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 XYes 2 No Maryland Baltimore City Baltimore City Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21214 USA 3105 Southern Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il yrs. College (1-4or 5+) Machinist Bare Truck Center Department of Health and Mental Hygie Important: If Item 27 is marked other I any injury or other traumatic event, II 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental Alice Augusta Smith Charles B. Doran, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 18 E. Eager St. Baltimore, Md. 21202 Nancy L. Dash 20b. Place of Disposition (Name of cemetery, crematory or other place)
Camp Chapel Meth. 20c. Location - City or Town, State Date 20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐ Removal from State 6-6-2009 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) permit. ²² Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 21. Signatule of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) cardiomyopathy **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Unerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 🗹 No 2 🗹 No certificate 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: 1 V Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES - 000 06 - 01- 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Good Samoriton Hospital Natallia Maroz Loch RAVEN Blvd 5601 Baltimore MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Elreda Davis 2 6 2009 8:30 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Harford Gardens N/A Balto 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F 219-26-4668 83 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f shov notified at XXYes 2 □ No Director MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ral", or items 23a or Examiner must be 21206 U S 5200 Bowleys LANE Α permit. Pages 1 and 2 should be filed within 72 hours after death w. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 2000. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 □ No If Yes, Give X Year or Dates: 1 ☐ Yes 2 X No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th grade 17. Father's Name (First, Middle, Last) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) Neolis Clark Mary Anna Cain 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt218 19a. Informant's Name/Relationship (Type. Print) Ernest Davis-Husband 5200 Bowleys Lane Balto, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Holy Redemption 6-10-09 Balto, MD 4 Donation 5 Other (Specify) 21. Signature of uneral Service and 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto,MD 21202 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician ar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending I for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably has been signed to the property of the propert Completed 24b. Were autopsy findings available prior to completion of cause of death?

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print)

them Words

State Registrar 31. Date filed (Month, Day, Year

		1	State of Maryland / Der 1- State Registrar Amend Items 26,30 per dr.,8	392,66/64/6941113 ^{and r} ertificate of Death	vientai myg R	leg. No. 2009	17853						
	DI .:::		1. Decedent's Name (First, Middle, Last)		2. Date of Deat Month	th 22ay 2009	3. Time of Death						
	Physicia /Medic		William Noah Ensor Jr.		May		8:54 Р м						
***	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death							
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	Funeral Director		5. Social Security Number 219-18-0705 6. Sex 7. Age (In yrs. last birthda 1	Months Days Hours Min.	8. Date of Birth (Month, Day pril 10	, 1925 Mar	yland						
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	be filed within 72 hours after death with the Maryland that Hygiene. ad other than "natural", or items 23a or 28a-f show event, it is siled. Evening the profiled at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	B. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)		e, etc.						
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Maryland	shoul ind M ind M	-	19a. Informant's Name/Relationship (Type. Print) 19b. Ma	illing Address (Street and Number or Ru	ıral Route Numbe	er, City or Town, State, 2	Zip Code)						
Ž	alth a		Truth Ensor/wife 4010	Leese Farm Drive	Manches								
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	To th withir To th comp	Me	29b. Signature and title of certifier	29 License number	?_	29d. Date signed (Mor	oth, Day, Year)						
			30. Name and address of person who completed cause of death (Item 23a) (Ty Flavio Kruter, M.D., 555 South Center)	pe, Print) er Street, Westmins	ster, MD	21157							
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urs af	Certification:		Single Family		8 Begor	rown, State) nia Court, Parkville, M D	
Divisior To the Hospital or Attend within 24 hours after dever- To the Funeral Directors completely filled in by the t	2	29a. Certifier 1 Certifying Physician: To the be	est of my knowledge, de	eath occurred at the time, d	ate and place, and due to the	ne cause(s) and manner as	stated.
To the Howithin 24 h	edical	one) 2 Medical Examiner: On the basis	of examination and/or stated.	investigation, in my opinion	n, death occurred at the time	e, date and place, and due to	the cause(s)
₽ № ₽ 8	Me	29b. Signature and title of certifier		29c. Licens	se number	29d. Date signed (Month, Day, Year)
_		0 1	1	O.C.	M.E.	May 31, 2009	
		30. Name and address of person who completed ca	use of death (Item 23a)				
2		Jack Titus MD. Deputy Chief Med	ical Examiner	111 Penn Street, Ba	Itimore, MD 21201		
	tate	31. Date filed (YON) Day, Year 2009	Registrar's Signature	bares			
Regis	trar	0011 U 4 2003 Aer	wa p. y	and a			

			State of Maryland / E	Department of Health and Menta Certificate of Death	Hygiene Reg. No. 2009 17855		
	1. Decedent's Name (First, Middle, Last)			2. Date Mor	of Death th Day Year 3. Time of Death		
All	/Medical			4b. City, Town, or Location of Death	AY 31 2009 8:00AM M 4c. County of Death		
and a	Examir	ier	9110 CARLISLE AVENUE	BALTIMORE COUNTY	BALTIMORE		
	Funeral Director			thday) If Under 1 Year If Under 24 Hrs. 8. Date (Mory Yrs. Days Hours Min. Oct	e of Birth nth, Day, Year) 5. 4,1919 9. Birthplace (State or Foreign Country) Maryland		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it is redicted Examinating to notified an once.	tor	Usual Residence of Decedent 10a. State	n or Location Baltimore Cou	unty 10d. Inside City Limits 1 □Yes 2 □XNo		
		al Direc	10e. Street and Number 9110 Carlisle Avenue	10f. Zip Code 21236	10g. Citizen of What Country? USA		
		Completed by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 No. 11 Yes, Give WW 11 Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, e 1 □Yes 2 🛛 No Specify:	Specify: White		
		omplete	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Railroad Trainman	Patapoco & Back River Railroad Co.		
Maryland 2		To Be C	17. Father's Name (First, Middle, Last) William O. Fetterhoff	18. Mother's Name (First, Georgiana			
Mar			Marie Fetterhoff (Wife)	Mailing Address (Street and Number or Rural Route 19110 Carlisle Avenue Balt	cimore, Md. 21236		
nore	Pages 1 nent of H ant: If Iter ary or oth		I MY Burial 2 L I Cremation 3 L.I Bernoval from State 1	Disposition (Name of ry, crematory or other place) and Memorial Pk. 6-4-200	20c. Location - City or Town, State Baltimore, Md.		
Baltimore,	permit. Page Department of Important: If any Injury or once.		4 Donation 5 Other (Specify) MOPELS 21. Signature of Funeral Service Licensee	²² LងssatMdr TuffeTal Home 7401 Belair Rd. Balti			
			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause or each line.		atory arrest, Approximate Interval Between		
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):				
	re death certificate be executed the attending physician and the for use as the burial-transit	Jer	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence	of):			
0,		Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence consequence) C. Due to (or as a consequence)	of):			
38760,		dical	d				
O. Box 6		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No. 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year		
S, P.	es that the de gned by the a be detached for		Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I. 23	e. Did tobacco use contribute to the cause of death?		
Records,	w requires t s been signe should be c	Completed by	Hypertension	24	a. Was an 24b. Were autopsy findings available		
Re	ysician: The law is certificate has b director, page 2 s	Comp			autopsy prior to completion of cause of death? Yes 22-40 1 Yes 2 No		
Vital		Be	25. Was case referred to medical examiner?	26. Place of Death (Chec			
J Of	ling Phys 1. After this funeral di	n: To	27. Manner of Death 28a. Date of Injury 28b.	itpatient 3 DOA 4 Nursing Home 34	Residence 6 Other (Specify)		
Division of	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director; After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	icatio	2 Accident investigation 3 Suicide 6 Could not be	M 1 Tyes 2 No	eation (Street and Number or Rural Route Number,		
Div		Certification: To	4 Homicide determined building, etc. (Specify)	City	y or Town, State)		
		Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination at and manner stated.				
		Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)		
30. Name an address of person who completed cause of death (Item 23a) (Type				(Type, Print)	June 2, 2009		
tos Digital Dreive, quite 6 Unilarium MD 21090							
	Sta Regist		31. Date filed (Month, Day, Year) JUN 0 4 2009 Shows S. Ager	4			
DH	MH 17 Rev 1/2	2001	Jan person p. par	PARIGINAL			

CARROLL TETTERHOFF

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Day Physician 2009 5:45 a ^M June V. Faison Estella /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Camp Springs 5719 Keppler Rd. Birthplace (State or Foreign Country)
 NC If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, . Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F Yrs. July 1920 88 243-76-4671 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wedical Evantual or ust be notified at 1 □Yes 2 X No Director MD Prince Georges Camp Springs 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20748 5719 Keppler Rd. Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 🔼 No Specify: þ 3 ☑ Widowed 4 ☐ Divorced Black Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Housewife 5th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fin and Mental F Be Martha Faison Charlie Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health tem 27 is Camp Springs, MD. 20748 5719 Keppler Rd. Mary Faison-Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 ament of H 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or c 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington National 6-6-2009 Suitland, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home of Maryland Signature of Funeral Service License 4308 Suitland Rd. Suitland, MD. 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Malignant Neoplasm of Uterus **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): ng physician as the burial P.O. Box 68760 Physician/Medical attending p IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) ☐Yes 2 No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has briector, page 2 s autopsy performed? 2 No 1 ☐Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🖸 Residence 6 ☐ Other (Specify) 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

ORIGINAL

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-04327 State of Maryland / Department of Health and Mental Hygiene Robert Galey Certificate of Death 1- For State Reg. No Registra 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day May 30, 2009 2322 hrs Robert L. Galey Medical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Baltimore Washington Medical Center Pasadena 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 24Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Country) Months Days Hours May 16, 1965 Director Indiana 213-96-9668 1 X M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10a. State 10b. County Yes 2 X No Anne Arundel Pasadena MD 28a-f show l other than "natural", or items 23a or 28a-f shothe Medical Examiner must be notified at once. hours after death with the Maryland Director log. Citizen of What Country? 10f. Zip Code 21122 10e. Street and Number USA 1522 Long Point Road Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) A Never Married Yes White Yes 2 X No specify: Specify: f Yes, Give Year Widowed Divorced ð 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) timore, MD 21215-0036

1. Pages 1 and 2 should be filed within 72 hot ment of Health and Mental Hygiene. Transit If item 27 is marked other than "nat yor other transmatic event, the Medical East yor other transmatic event, the Medical East yor other transmatic event, Elementary/Secondary (0-12) College (1-4 or 5+) I T Specialist Self 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frances Jean Peperak Kenneth Lee Galev Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kenneth Lee Galey 1522 Long Point Road, Pasadena, Maryland 21122 (Father) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State June 9, 2009 Clinton, Indiana Walnut Grove Cemetery mportant Other Specify: Donation þ 22. Name and Address of Facility McCully Polyniak Funeral Home PA neral Service Licensee 21. Signature of 3204Mountain Road Pasadena MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. (Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit Records, P.O. Box 68760, The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. signed by i Part II. Other significant conditions ģ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a. Was an certificate has been prior to completion of cause of autopsy death? performed? No Yes 2 ✓ Yes 26.Place of Death (Check only one) director, 25. Was case referred to medical the Hospital or Attending Physician: Division of Vital Be Other; Hospital: Other 2 V ER/Outpatient 3 Nursing Home 5 Inpatient 1 Yes 28d Describe how injury occurred After t 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 1 V Natural Yes 2 No Pending the Director: 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc hours after 3 Could not be Suicide or Town, State) Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 1 one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified May 31, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Carol Allan, MD 31. Date filed (Month, Day, Year) 32/Registrar's Signature State Registrar

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Jun ne /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Sinai Hospital of Raltimore Baltimore If Under 24 Hrs. If Under 1 Year 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Hours Min. 1 ☐ M 2 💢 F Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be rutified at any injury or other traumatic event, the Medical Examinar must be rutified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Sorden, (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) Husband altimore. Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 DOther (Specify) 22. Name and Address of Facility
JOSEPH
222-2 W. NDTH 21. Signature of Funeral Service Licenses 23a. Parti / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Breast **Physician** Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter of control of that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 **N**o signed by the a P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown been sis Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has t autopsy performed certificate 2 No Division of Vital 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2**⊠**No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Aftert Certification: 1 Natural 5 Pending ithin 24 hours after death.

5 the Funeral Director: Aft
5 mpletely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Aushim Bhatia, MD Sinai Ha

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

12:00 AM

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

lyear

Day

1 ☐Yes 2 MNo

June 1,2009

Bultimore, MD 2126

Year

Month

1 Yes 2 No

2009

State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

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Sinai Haspital of Baltimore

State of Maryland / Department of Health and Mental Hygiene ? 1 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Vear Physician REGINALD 6:14 AM 2009 MAY /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner JOHNS HOPKINS BAYVIEW MEDICITE BALTIMORE CENTEN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. Jan 7, 1940 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 € M 2 □ F Months Maryland 69 219-36-0194 Director Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 10h County ir than "natural", or items 23a or 28a-f show 1√∑Yes 2 □ No MD Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5009 Frankford Avenue 21206 USA Completed by Funeral hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) car wash 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Evans Gaither ၉ <u>Catherine Virginia Williams</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Jenkins/sister 6012 The Alameda Baltimore, MD Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Services Licensee S. Wade 22. Name and Address of Facility Vicetor State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician year 1 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Usease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed and-tran Due to (or as a consequence of) burial-Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a ☐Yes 2 ☐ No Ö 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 1 ☐ Yes 2 ☐ No of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☑Natural To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 028684 Deaswill 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 4940 EASTERN AVENUE BALTIMONE, MD Edwara 5- besiman

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

09-04328								
Colin	Gaynor							

lin Gaynor	1-	amend #5 PSTate of Maryland Abepartment of Certificate of	Death R	eg. No. 2009 1786				
Physiciar	1/ 1	egistrar Decedent's Name (First, Middle,Last)	2. Date of Dea Month May 31, 2	th 3. Time of Death Day Year 0105 hrs				
edical Examin		COIN GAYNOR a. Facility Name (if not institution, give street and number) 4	b. City, Town, or Location of Death	4c. County of Beating				
<i>∮</i>		Harbor Hospital	Baltimore If Under 1 Year If Under 24Hrs. 8. Date of Bi	rth (MM/DD/YYYY) 9. Birthplace (State or Foreign				
Funeral Director	5	Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Months Days Hours Min.	972 Country) MD				
, k	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	on	10d. Inside City Limits				
Maryland 28a-f show any d at once.		Tob. County	od lawn	1 Yes 2 No				
by MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. trem 27 is marked other than "natural", or items 23a or 28a-f shortraumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 16 Heatherton Court	10f. Zip Code 21244	10g. Citizen of What Country?				
eath with the items 23a o	a l	11. Marital Status 12. Was Decedent Ever in U.S. 13. Wa	s Decedent of Hispanic Origin? (Specify Yes or Nes, specify Cuban, Mexican, Puerto Rican, etc.)	o- 14. Race - American Indian, Black, White, etc.				
er death , or iten	리	1 Never Married 2 Married 1 Yes 2 No	Yes 2 X No specify:	specify: Black				
2 hours after "natural", Examiner	함	15. Decedent's Education (Specify only highest grade completed) 16a. Deceden during m	it's Usual Occupation (Give kind of work done ost of working life. DO NOT use retired)	16b. Kind of Business/Industry				
136 hin 72 h e. than "n	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade N/A D	ispatcher	Trucking company				
, MD 21215-0036 and 2 should be filed within 72 hours after cellth and Mental Hygiene. tem 27 is marked other than "natural", traumatic event, the Medical Examine.	<u>ا</u> ۾	17. Father's Name (First, Middle, Last) Marvyn L. Gaynor, Sr.	18.Mother's Name (First, Middle Dancen	, Maiden Surname) Wens				
212' ould be d Menta s marke		19a. Informant's Name/Relationship (Type, Prin) (Nother) 19b. Mailing	g Address (Street and Number or Rural Route No	umber, City or Town, State, Zip Code) 2117				
e, MD I and 2 sho Health and item 27 is	-		Mestead Drive Apt. I sition (Name of cemetery, Date	20c. Location - City or Town, State				
More Pages 1: int: If if r other		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: King Men	1000 Park 06/06/04					
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other traun	1	21. Signature of Funeral Service Ligensee 22. I	Name and Address of Facility Jaughn 3728 Liberty Kood R	C. Greene Funoral Sto andall stown MD 21133				
Physician	+	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.						
/vedical taminer	Amendate Course (First disease a Dilated cardiomyonathy							
	Examiner	Sequentially list conditions, if any, leading to immediate bulleto (or as a consequence of):						
		cause. Enter Underlying Cause (Disease or injury that initiated Due to (or ac a consequence of):						
tecuted and transit		d.	erME, g892 6/5/09 TT					
6 be execut ysician and burial - tra	ledical	X UNPENDED AMENDED 23a, P11, 27, p6 IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery				
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed reteath. retean: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transi	sician/M	23b. Was decedent pregnant in the	etal death 3 Ectopic pregnancy Other (Specify)	Month Day Year				
Box a death of the atter	Physic	1 Yes 2 No 9 Unknown 9 Unknown		d tobacco use contribute to the cause of death?				
ires that the signed by	-	Part II. Other significant conditions contributing to death but not resulting in the Obesity	diddifying sales give	Yes 2 No 3 Probably 4 ✔ Unknown				
ords, w require s been sig	Completed by			as an 24b. Were autopsy findings available prior to completion of cause of death?				
tal Recorcian: The law 1 certificate has tector, page 2 sh	omp		1 ✓ Y€	es 2 No 1 Yes 2 No				
Vital ysician: his certifi director,	Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatie	26.Place of Death (Check only one) nt 3 DOA Other A Nursing Home 5	Residence 6 Other:				
n of Vi ding Physi After this funeral dir	on: To	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of X	f Injury 28c. Injury at Work? 28d. Descri	be how injury occurred				
Division tal or Attendi rs after death.	Certification:	2 Accident Investigation 28e. Place of Injury - At home, farm, str	reet, factory, office building, etc. 28f. Location	on (Street and Number or Rural Route Number, City on, State)				
fig on bi	Certif	4 Homicide determined (Specify)						
ag the High	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ (Check only one) 2 Medical Examiner: On the basis of examination and/or investige and manner stated.	gation, in my opinion, death occurred at the time, d	late and place, and due to the cause(s)				
To with	Me	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) May 31, 2009				
1 ot med		30. Name and address of person who completed cause of death (Item 23a)	n Street, Baltimore, MD 21201					
1 1								
9	State 31. Date filed (Month, Day, Year) 32. Registrar's Signature							

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician 22:50 PM 2009 arie une /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Battima If Under 1 Year | If Under 24 Hrs. Barriew Medical Center Johns Hopkins
Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 □X 100 09/05/1908 Maryland Director 213-26-3760 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, Its Medical Examinat must be notified at X Yes 2 No Director **Baltimore** Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21224 U.S.A. 1300 South Ellwood Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates Specify þ 3 ₩ Widowed 4 □ Divorced Completed 6b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) UNKNOWN College (1-4or 5+) Elementary/Secondary (0-12) UNKNOWN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Simon Fraling Josephine Cook 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 715 Maiden Choice Lane, Catonsville, Maryland 21229 Elaine Chambers / Niece 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 06/06/2009 Baltimore, Maryland Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Signature of Funeral Service Licenses 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death days Immediate Cause (Final disease or condition resulting in death) **Physician** Preumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tran Due to (or as a consequence of): signed by the attending physician d be detached for use as the buria P.O. Box 68760 certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown cate has been si page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 21☑No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Eastern Avenue.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 3:24 P M 2009 Pauls Hardy June Miriam /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Ballinore Hospital n/a Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days 1 □ M 2 🛛 F Missouri 97 Feb 4, 1912 Director 220-30-3088 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 1 X Yes 2 □ No Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any injury or other traumatic event, it is done to the traumatic event, it is done to the traumatic event, it is done to the traumatic event. Director Baltimore City Maryland n/a 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 2533 Pickwick Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No 1 ☐ Yes 2 🕱 No Specify: Specify: à White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry School of Hygiene Elementary/Secondary (0-12) College (1-4or 5+) and Public Health Professor 12 5+18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ottesky Amelia Pauls ပ Otto 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baratra Court, #204, Timonium, MD Elin Gursky/Friend 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Glen Burnie, Maryland 6/8/09 Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc. 21 Signature of Funeral Service Licen Bryan W. Clary 10 W. Padonia Road, Timonium, Maryland 23a. Part 1. Inter the sease, or complications that caused shoot, or heart faiure. List only one cause on each li Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Find disease of the country resulting in eath) **Physician** Minutes /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-tran and Due to (or as a consequence of): attending physician certificate be Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown signed by the best of the detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?/ yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number

Baltimore, Maryland 21215-00. Box 68760. P.O. Division of Vital Records, To the Hospital or Attending Physician: The within 24 hours all or death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag

Rosen at

31. Date filed (Month, Day, State Registrar

29b. Signature and title of certifier

Kireët

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital 32. Registrar's Signature

ES 000

ORIGINAL

29d. Date signed (Month, Day, Year)

Battimore, 2401, W-Belveders Battimore MO

21215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** June 2009 6:05 PM **Betty Jane Howard** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist Hospice 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 □ **X**F 218-38-3039 68 MD Director Feb. 24 1941 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland. Department of Health and Mental Hygiene. Important: If itiem 27 is marked other than "natural" ~-: any injury or other traumatic events. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Yes 2 No Cockeysville Director Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **USA** 21030 20 Gibbons Blvd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12, Was Decedent Ever in U.S. Armed Forces 1 Never Married 2 Married white 1 ☐ Yes 2 X No Specify. þ Yes, Give 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PHH (leasing) Data Entry 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pearl Fishpaw Joseph Cole ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20 Gibbons Blvd., Cockeysville, MD 21030 Donzell Howard/husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jessops Cemetery 6/6/09 Sparks, MD Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 21. Signature of Funeral S Inc. Mike ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final WEEKS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause E leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Year detached for 5 Other (specify) 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? nis certificate has been signed director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? STROKE 24a. Was an autopsy performed this certificate CORONARY ANTERY DISEA. 1 ☐ Yes 2 No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 064395 29b. Signature and title of certifier JUNE 2,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DANIEUE DOBERMAN,

ND 6565 N CHAPUS ST, SUITE 209

32. Registrar's ignat

BALTIMORE, MO 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year (-) 28A, M 09 Loui 6 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number Age (in yrs. Baftimore you Rehel Cation Extery If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign curity Number last birthday Days 1 M 2 □ F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐Yes 2 ☐ No 10g. Citizen of What Country? 10e. Street and Number Was Decedent Ever in U.S. Armed Forces? 1 (1) Yes 2 □ No If Yes, Give Year or Dates: WW1 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. PO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Tywn, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (ame f emetery, cremator or ot e place) -5^{Date}09 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation / 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. and J. Errfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh. ck, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death Due to (or as a consequence of): 10 hermen Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or Injury that initiated events resulting in death) Last Due to or as a consequence of): Due to (or as a consequence of):

Physician /Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed

1 - For State Registrar

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

þ

Completed

Be ပ

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Modical Examinar must be rediffed at

permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene Important: If item 27 is marked other (tran "na any Injury or other traumath.

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran Physician/Medical ģ Be Completed Certification: To within 24 hours after death. To the Funeral Director: A

Division of Vital Records, P.O. Box 68760,

Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		3 🗌 Ectopi 5 🗌 Other	c pregnancy (specify)		23d. Date of delivery Month Day Year
ģ	Part II. Other significant conditions	contributing to death but not resulting in the	e underlyin	g cause given in Part I.		co use contribute to the cause of death? 2 □ No 3 □ Probably 4 ☑ Unknown
Completed					24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Be (25. Was case referred to medical			26. Place of De	eath (Check only one)	
고 B	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ☐ ER/Outpa	itient 3	DOA Other: 4 Nursing	Home 5 Residence	e 6 ☐ Other (Specify)
ation: 1	27. Mary er of Death 1 √ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Tim Injur		28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how it	njury occurred
Certification:	3 ☐ Suicide 6 ☐ Could not determined		street, fact	tory, office	28f. Location (Stree City or Town, St	t and Number or Rural Route Number, tate)
Medical (29a. Certifier 1 CertifyIng F (Check only one) 2 Medical Exa	Physician: To the best of my knowledge, d aminer: On the basis of examination and/c and manner stated.	eath occur or investiga	red at the time, date and pla tion, in my opinion, death oc	ce, and due to the caus curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
ĭ	29b. Signature and title of certifier	1		29c. License number	29d.	Date signed (Month, Day, Year)

06 02

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lah

JUN 0 4 2009

filed (Month, Day, Year)

M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 05 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and g 4b. City, Town, or Location of Death Examiner Kanda 115. more Carriag If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number last birthday, 9. Birthplace (State or Foreign Funeral Months 1 □ M 2 💢 F Director Usual Residence of Decedent Pages 1 and 2 should be filed withIn 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County show items 23a or 28a-f shoviner must be notified at 1 Yes 2 □ No Director 061 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) ral", or items Black, White, etc. ☐Yes 2 No Yes, Give 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 🗆 Yes Specify: 3 Widowed 4 ☐ Divorced Year or Dates: "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical than Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygin Important: If item 27 Is marked other any injury or other traumatic event, ti 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 20a Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses of 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on yach live. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respirator Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra physician the burial Division or Vital Records, P.O. Box 68760, Physician/Medical as attending plant for use as IF FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an s certificate has the irector, page 2 s autopsy performe 1□ Yes 2 N director, 25. Was case referred to edical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐Other (Specify) Medical Certification: To this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral i 28a. Date of Injury (Month, Day Year) 27. Mann 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determine 4 Homicide Destifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar 30. Name and add

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1	For State Registrar	State of M	laryland		rtment			and Ment		ene 1. N2 0 (09	17866
Physiciar	_	1. Decedent's Name (First, Middle,	Last)						N	ate of Death	Day	Year	3. Time of Death
/Medica	Ĺ	Margie Mae Ha					-			ay 22,		- (D 1)	12:00 AM
Examine		4a. Facility Name (If not institution, g Frostburg Vill		,			stbu	Location of	of Death		4c. County	egany	
Funeral			. Sex 7. A	ge (In yrs. last	birthday)	If Under	1 Year	If Under 2		ate of Birth		9. Birthp	lace (State or Foreign
Director		212-24-1021	1□M 2 X F	84	Yrs.	Months	Days	Hours	Min. Apı	nonth, Day, Y	1925	Coui West	Virginia
and	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation						1	10d. Inside City Limits
Maryl f sho	5	MD Allega	ny	Fre	stbu	rg							1 □ Yes 2x No
h the	2	10e. Street and Number				10f. Zip	Code			100	g. Citizen of	What Cou	ntry?
23a c	ם _	159 Ormand Stre	et				21	L532			US	A	
412.15-UU36 4 within 72 hours after death with the Maryland liene. Then "naturel", or items 23a or 28a-f show the Medical Exertiral must be notified at	2	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ XWidowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 Yes 2 11 Yes, Give Year or Dates:	Ever in U.S. ? No	1	Vas Deced fYes, spec I□Yes 2		spanic Orig n, Mexican, Specify:	gin? (Specify \ i, Puerto Rican	es or No- , etc.)	Bla	ce - Americk, White, y: Whi	
72 hoursturn dices is	- 100	15. Decedent's	Education	1	6a. Deced	lent's Usua	l Occupa	tion	t of working	16	6b. Kind of B	usiness/In	dustry
21215-0036 ed within 72 hours af vgjene. ser then "naturel", or it, it is Medical Exert	2	Elementary/Secondary (0-12)	College (1-4or	5+)	life. l				t of working				
W 0 0 0	3	8 17. Father's Name <i>(First, Middle, La</i>	0			hous			r's Name (Firs	A A A int at a A A a		home	
E Bag D	ă	Frank Bernard	•						Len Mae			110)	
ts be me	-	19a. Informant's Name/Relationship		11	19b. Mailin	g Address	(Street a		r or Rural Rou			State, Zip	Code)
C = W =		Diana McKenzie	/daughter		1300	8 E11	ersl	ie Ro	oad NW	Cumber	land,	MD 2	1502
		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 🎇 Donation 5 ☐ Other (Spe	cify) /	0.000	e of Dispo etery, cren	sition (Nam natory or ot	ne of ther place)	Date	20	c. Location	City or To	own, State
Baltimo permit. Page Department o Important: If any injury or		21. Signature et Euneral Service Lic Ronald S	Wade, Win	eror	St	Name and ate A 1time	nato	my Bo	bard 65	5 W. B	altimo	ore S	treet
oentificate be executed centificate be executed wing physician and lise as the burial-transit centificate because with the control of the centility of the cent	Ical Eva	23a. Parti. Enter the disease, of or shoot, or heart failure. List on Immediate Chase (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	by one cause on each land a. Ather Due to (or as	ine.	evoluce of):	1			V4500			se	Approximate Interval Between Onset and Death
BOX 08 Beath certifica attending ph	COLD INICO	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic pre	egnancy					te of delive	•
T.O. BOX OS nat the death certifics d by the attending pt letached for use as t	1391	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∏Pregnant a 9∏ Unknown	t time of deati	h 5□	Other (spe	ecify)					onth	Day Year
igne igne	2	Part II. Other significant conditions Chromic C	bstruch		ng in the ur		susa givai Sea	_				tribute to t	he cause of death? pably 4 Unknown
The tay ate has page 2) <u> </u>									4a. Was an autopsy performs	ed3	Were auto prior to co death? 1 ☐ Yes	opsy findings available impletion of cause of
Of VICAL Physician: T this certificat ral director, pr	3	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:		10		Other		of Death Che		a Clau	10	
Phy g Phy er this eral d	-	27. Manner of Death	1 ☐ Inpati	ury 28	Outpatien b. Time of		Bc. Injury Work	4 Nur	rsing Home	5 Hesiden Describe how			ý)
inding ath. rr: Afte		1 Natural 5 Pending Investigat	(Month, Da	ay rear)	Injury	М		? es 2 □ N	No				
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	۱ (3 Suicide 6 Could not 4 Homicide determine	ed 286. Place of in building, e	tc. (Specify)					0	ity or Town,	State)		al Route Number,
the Hospi nin 24 hour the Funer npletely fill		29a Carifier 1 Continuing (Check crity one) 1 Medical Ex	aminer: On the basis of and manner s	of my knowle of examination tated.	dga death and/or inv	vestigation,	at the ting in my opi	a, date and inion, deat	diplace, and di thioccurred at	the time, date	e and place,	anner as s and due t	o the cause(s)
To t Within Com		29b. Signature and title of certifier Www.co-c	Physicism: To the best aminer: On the basis of and manner stand manner	MD		290	DO	number	325	290	a. Date signe	d (Month,	2009
		30. Name and address of person wh	o completed cause of	Biche	sa) (Type,	alch	Rd	Can	uberli	end I	MP21	50Z	
State		31. Date filed (Month, Day, Year)	32. Regist	rar's Signatur		- 3,,,			7.		1		
Registrar		JUN 0 4 2	2009 Due	u s	1	whol	,						

DHMH 17 Rev 1/2001

ORIGINAL

531 09 (834 PM) Baltimore, Maryland 21215-0036 Henry Frank-MS001478520 Division or Vital Records, P.O. Box 88760,

	1 - For State Registrar		(Certificate of	Death	B	leg. No. 200	9 1786
	1. Decedent's Name (First, Middle,	Last)				2. Date of Dea Month	ith Day Year	3. Time of Death
sician edical	FRANK	GORDON H	HENRY			May	31 2009	18:34 p ^M
miner	4a. Facility Name (If not institution,	ive street and number)		4b. City, Town, o	or Location of Death		4c. County of Dea	ith
	UPPER CHESAPEA	KE MEDICAL (CENTER	BELA			HARFOR	D CO
ral	Social Security Number 6	.Sex 7.Age 1.XM 2□F	(In yrs. last birth	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	y, Year) 9. Bir	thplace (State or Foreign ountry)
or	217-52-9713	T ZBIVI Z I	60 ^Y	rs.		MAY 6	1949 VI	RGINIA
	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
5				3 D = 1/4 D				1 ∐Yes 2XXNo
Director	MARYLAND HARFO	RD CO		ABINGDO	JN		10g. Citizen of What C	ountry?
		- Y 7 T-1			009		U.S.A.	•
Funeral	909 HAMBURG DR	12. Was Decedent E	ver in U.S.	13. Was Decedent of H		pecify Yes or No-		
듄	1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 □ Yes 2√CXN				o Rican, etc.)	Black, Whi	te, etc.
þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes XX No	Specify:		Specify:	BLACK
Completed	15. Decedent's	Education	16a. I	Decedent's Usual Occu Give kind of work done	pation	kina	16b. Kind of Business	/Industry
읦	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5-		life. DO NOT use retire	d)	Mily		
ğ	12 yrs	6yrs		YSICAL ED S	FEACHER		BALTO CO	SCHOOLS
Be (17. Father's Name (First, Middle, La	est)			18. Mother's Nam	ne (First, Middle,	Maiden Surname)	
2	GORDON F. HEN	RY			FANN	IE HENRY		
	19a. Informant's Name/Relationship	(Type. Print)	19b.	Mailing Address (Street	and Number or Ru	ral Route Numbe	er, City or Town, State,	Zip Code)
	Jessica Green	Henry/Wife		09 Hamburg	Dr., Abi			
once. To Be Completed by Funeral Director	20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 3	☐Removal from State	20b. Place of cemetery	Disposition (Name of v, crematory or other pla	ice)	Date	20c. Location - City o	r Town, State
	4 ☐ Donation 5 ☐ Other (Spe		METRO	CREMATORY	06-0		BALTIMORE,	
once.	21. Signature of Faneral Cervice Li	ensee		22. Name and Addr WILLIAM C	ess of Facility BROWN COI	MM FUNER	AL HOME-HA	RFORD, P.A.
ō	1115	2		321 S PH	[LADELPHI	A BLVD.,	ABERDEEN,	MD 21001
•	23a: Part1. Enter the disease, or conshock, or heart failure. List or	omplications that caused bly one cause on each lin	the death. Do no	ot enter the mode of dyi	ing, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
an	Immediate Cause (Final disease or condition	Acc	ute i	Myocara	lu/ I	infare	7,04	10 minutos
al	resulting in death)	Due to (or as a	a consequence o	f):				
er	Sequentially list conditions.	b						
leted by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence o	r):				
Examin	that initiated events resulting in death) Last	C	a consequence o	n·				
		540 10 (0) 40 0	2 0011004401100 0	.,,				
edical	10	d						
/We	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome s	pf pregnancy				, 23d, Date of de	elivery
Physician/M	in the past 12 months?	1□Live birth : 4□Pregnant at		3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су		Month	Day Year
ıysi	1 □ Yes 2 □ No 9 □ Unknown	9□Unknown						
	Part II. Other significant condition	s contributing to death bu	ıt not resulting in	the underlying cause gi	ven in Part I.	23e. Did to	obacco use contribute	to the cause of death?
d by	Ischemic	Cardion	yopa	thy		1 🗆 \	res 2□No 3□I	Probably 4 nknown
Completed		•		•		24a. Was	an 24b. Were	autopsy findings available
Ę					**		rmed? death?	
	25. Was case referred to medical				26 Place of Dea	th (Check only o		5 2 110
To Be	examiner? 1 X Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2X ER/Out	patient 3 DOA Ot	her:		dence 6 ☐Other (Sp	necify)
	27. Manner of Death	28a. Date of Injur (Month, Day	y 28b. T	ime of 28c. Inju			now injury occurred	
atio	1 Natural 5 ☐ Pending 2 ☐ Accident investiga		rear, III		Yes 2 No			
ii.	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ry - At home, fan	m, street, factory, office		28f. Location (5 City or Tov	Street and Number or I	Rural Route Number,
Certification:	4 Littornioide	bullarity, etc	. (Opechy)			City of You	vii, Glale)	
		Physician: To the best of						
edical	one)	caminer: On the basis of and manner sta				aneu at the time,	uate and place, and d	
Σ	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signed (Mod	nth, Day, Year)
) [//	no		43	5012		June 1	, 2009
	30. Name and address of son w	no completed cause of de	eath (Item 23a) (1	Гуре, Print)			1 11	0000
110	Kevin Lyne	h, M.D. E	000 Up	per Ches	apeake	Dr. B	el Air, 1	, 2009 MD 21014
State	31. Date filed (Month; Day, Year)	32 Pagistra	ar's Signature	0 ~	4		- 7	
jistrar	JUN 0 4 2	109 Jeneus	1.	parke				
			J /-					

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Amend 20b, perFh g892 6/8/09 TT
State of Maryland / Department of Health and Mental Hygiene

1- For State Amend #1 per MD g892 6/17/09 Entificate of Death

Reg. No. 200 1. Decedent's Name (First, Middle, Last)
Paul Mifflin Johnson 2. Date of Death 3. Time of Death Year **Physician** 08:20 AM 2009 Mufflin June Paul Johnson 9 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital of Baltimore Baltimore Baltmore City Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**√** M 2□ F Months 79 Director 218-28-5266 09 30 04 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Department of Health and Mental Hygiene, instural, or items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Wedical Examinar must be notified at once. 1 XYes 2 □ No Directo Baltimore MD NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21215 3701 Cedardale Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced au Johnson Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Educator 6yrs+ 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Ann Lee Edgar D. Johnson ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3701 Cedardale Road, Baltimore, Md 21215 Muriel Johnson-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 6/11/2009 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arbutus Memorial 6/10/09 Arbutus, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licenses 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Ulmonary 2 hours disease or condition resulting in death) , /Medical Due to (or as a consequence of): Examiner 2 days Thrombosis Sequentially list conditions, if any, leading to induction cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Ye ar 5 Other (specify) 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? 2 Disease 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?/ Yes 2 No 1 ☐ Yes 2 MNo 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RES-000 Tune 2,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital of Baltimore Henesch, MD Jonathan 31. Date filed (Month, Day, Year) 32. Pristrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Item 27 State of Maryland / Department of Health and Mental Hygiene per dr.,g892,06/04/09dhb Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Zas /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** CONTER MUDGITY Media TIMENE If Under 1 Year 9. Birthplace (State or Foreign 8. Date of Birth Day, Dec 31, 5. Social Security Number . Age (In yrs. last birthday) **Funeral** Days Hours Min Virginia 1 € M 2 □ F 69 226-54-8293 Director Usual Residence of Decedent 10d. Inside City Limits 10h. County 10c. City, Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 273 is marked other than "natural", or items 23a or 28a-f show any hjurp or other traumatic event, it, was fined Economic and to notified at 1 ☐ Yes 2 ☑ No Director Anne Arundel Severn 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21144 8076 Telegraph Road Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: \$58-63 1 ∐Yes 2 🛣 No Specify Specify: White þ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 mechanic automotive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hal Latham Justice Virginia Clark ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Anna Justice/spouse 8076 Telegraph Road Severn, MD 21144 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4

☐Donation 5 ☐Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. Signature of Juneral Script S. Wade. 21201 Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate ause (Final disease or condition resulting in death) YLEYBIRM Physician /Medical Due to (or as a consequence of) Examiner Dell Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-trar Due to (or as a consequence of) ed by the attending physician detached for use as the burial Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 1 ☐ Yes 2 500 1 ☐ Yes 2 ☑ No Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ ¥10 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28a 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day,

32. Registrar's Signature

Deneur S. Sparker

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Fow 1/9 (c)

09-04206

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

eroy Joiner.	1- For State	Department of Health and Mental Hy Certificate of Death	giene 2009 1787
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death 3. Time of Death
Medical Examiner	Lerov	Joiner	May 27, 2009 0001 hrs
	4a. Facility Name (if not institution, give street and number) St. Agnes Hospital	4b. City, Town, or Location of Death Baltimore	4c. County of Death
Funeral Director		In yrs. last birthday) 8 2 Yrs. If Under 1 Year If Under 24Hrs. Months Days Hours Min.	8. Date of Birth(MM/DD/YYYYY) 9. Birthplace (State or Foreign Country) N.C.
	246-26-8470 XXM 2 F Susual Residence of Decedent	82 Yrs.	00 20 20 20
w any	10a. State 10b. County 10	Oc. City, Town or Location	10d. Inside City Limits 1 X Yes 2 No
yland -f show once.	MD NA 10e. Street and Number	Baltimore [10f. Zip Code]	10g. Citizen of What Country?
th the Maryland 23a or 28a-f sh antified at once	820 South Caton Ave	21229	U.S.A.
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director		If Yes, specify Cuban, Mexican, Puerto F	
ural", miner	Widowed 4 Divorced If Yes, Give Year or Dates. 15. Decedent's Education (Specify only highest grade complete.	1 Yes 2 No specify: eted) 16a, Decedent's Usual Occupation (Give kind of wo	Specify:
72 hours na "natu cal Exan	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use retire	od)
21215-0036 uld be filed within 72 hours Mental Hygiene. marked other than "nature event, the Medical Exam To Be Completed B	12th grade na 17. Father's Name (First, Middle, Last)	Laborer	Various Jobs
215- be filed antal Hyg rked off	Leroy Joiner Sr.		Wallace
2121 tould be fi Mental S marked tic event,	19a. Informant's Name/Relationship (Type, Print)		ural Route Number, City or Town, State, Zip Code)
MD and 2 shot and cen 27 is raumati	Ann Clark-Daughter 20a. Method of Disposition	4005 Barrington Av 20b. Place of Disposition (Name of cemetery,	e, Baltimore, Md 21207 Date 20c. Location - City or Town, State
Baltimore, MD 21215 permit. Pages I and 2 should be file Department of Health and Mental H Important: If item 27 is marked of injury or other traumatic event, it	1 X Burial 2 Cremation 3 Removal from State	crematory or other place)	
altin mit. Pa partmet portan ury or	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Garrison Forest Vet 6	
	23a. Part/Enter the disease, or complications that caused the	March F/H West 4366 Wabash Ave,	
Physician	failure. List only one cause on each line.	ardiovascular Disease	Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cause or condition resulting in death) Due to (or as a consequence)		
her	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of the conditions)	uence of):	,
ted Insit Examiner	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of the con	uence of):	
execu an and al - tra	d. UNPENDED AMENDED	·	
760, cate be physici he buri	IF FEMALE: 23c. If yes, outcome		23d. Date of delivery
Box 6876(death certificate the attending phy dfor use as the b	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic pregnan me of death 5 Other (Specify)	cy Month Day Year
by the attending phyched for use as the Physician/M	1 Yes 2 No 9 Unknown g Unknown		
ries that the signed by be detach	Part II. Other significant conditions contributing to death be Chronic Obstructive Pulmonary Disease	out not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown
ords, we requires is been signatured because of the second part of the	Official obstitutive Fallionary Disease		24a. Was an 24b. Were autopsy findings available
Records, The law requires ficate has been sig page 2 should be Completed			autopsy performed? 1 Yes 2 No 1 Yes 2 No
ital Relation: The certificate ector, page	25. Was case referred to medical	26.Place of Death (Check of	
f Vital Physician or this cert ral director	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient	2 FR/Outpatient 3 DOA Other Mursing	Home 5 Residence 6 Other:
n of ding Ph After t funeral	27. Manner of Death 1 ✓ Natural 5 Pending 28a. Date of Injury (Month, Day, Year		28d. Describe how injury occurred
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rape after cleath. al Director: After this certificate has been signed by ted in by the funeral director, page 2 should be detactly artification: To Be Completed by P	2 Accident Investigation 28e. Place of Injur		28f. Location (Street and Number or Rural Route Number, City
Division o spital or Attending nours after death. neral Director: Aft filled in by the function:	3 Suicide 6 Could not be determined (Specify)		or Town, State)
Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the t Medical Certification: To Be Completed by Physician/MA		knowledge, death occurred at the time, date and place, and on nation and/or investigation, in my opinion, death occurred at	
Me G T W T	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	to be - tole	O.C.M.E.	May 27, 2009
	Name and address of person who completed cause of dea Patricia Aronica-Pollak MD. Assistant Me	ath (Item 23a) edical Examiner 111 Penn Street, Baltimore	e, MD 21201
State	31. Date filed (Month, Day, Year) 32. R gistrar's	Signature	
Registrar	JUN 0 4 2009 /known	I parts	
DHMH 17 Rev 1/2001	00115	ORIĞINAL	

DHMH 17 Rev 1/2001 OCME 2006

			For State Registrar		State of M	larylan		artment of H		d Mental H	ygiene Reg. No.	2000	17070
	Dhysisi		1. Decedent's Name	(First, Middle,						2. Date of I		Year	3. Time of Death
	Physici /Medi		Mamie			ouis	е		mes	05	30	2009	3:45a.™
	Examir	ner	i i		give street and number	r)		4b. City, Town, or		eath	4c.	County of Death Baltim	
	Funeral		Stella M 5. Social Security Nur			ge (In yrs.	last birthday)	If Under 1 Year			Birth	9. Birth	place (State or Foreign
	Director		218-22-3	3207	1□ M 2 F	83	Yrs.	Months Days	Hours N	fin. 03	27 2	26 Coul	NC NC
	and		Usual Residence of D	Decedent 10b. County		10c. Cit	y, Town or Lo	cation				1	10d. Inside City Limits
	Maryl:	호	MD	N	A		Balti						1 X Yes 2 □ No
	r 28a	irec	10e. Street and Numb	ber				10f. Zip Code			10g. Citi	zen of What Cou	ntry?
	th with	a D	3313 Mon	dawmi	n Ave			2	1216			U.S.A.	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Eva	by Funeral Director	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4		12. Was Deceden Armed Forces 1	? No		Vas Decedent of H fYes, specify Cuba I∐Yes 2√∑No	ispanic Origin' n, Mexican, Pi Specify:	? (Specify Ye's or fuerto Rican, etc.)		14. Race - Ameri Black, White, Specify: B1	
5-0	72 hor	Completed by	(Specif	15. Decedent's	Education grade completed)		16a. Deced	lent's Usual Occupa	ation	working		nd of Business/In	•
2	ithin ne. han	ag m	Elementary/Second	dary (0-12)	College (1-4or	5+)	life. L	OO NOT use retired		_			o State
	iled w Hygie ther ti		12th gra		2yrs		Lice	nsed Pr		Name (First, Midd		spital	
an	d be fental ked o	To Be	Jarvis H	_	. ,					ie Bail		ourname,	
Maryland	shoul and M s mar umati	F	19a. Informant's Nan		(Type. Print)		19b. Mailin	g Address (Street				r Town, State, Zij	o Code)
	and 2 salth a 1 27 ls		Oliver J	[ames-]	Husband		3313	Mondaw	min A	ve, Bal	timo	ce, Md	21216
ore	of He of He if item		20a. Method of Dispo	sition	☐ Removal from State	20b. P		sition (Name of natory or other plac		Date		cation - City or To	
Ë	Pag Iment tant: I		4 Donation 5			. Ga		n Fores		6/8/09	Ow:	ings Mi	lls, Md
Baltimore,	permit. Pages 1 and i Department of Health Important: If item 27 any Injury or other tr 2016.		21. Signature of Fun	eral Service Lic	L- mes)	Ма	Name and Address rch F/H	West	e, Balt	imore	e, Md 2	21215
	Physician		shock, or heart Immediate Cause (F	failure. List on inal	mplical ins that cause ly one cause on each	line.				diac or respiratory	arrest,		Approximate Interval Between Onset and Death
7	/Medical Examiner		disease or condition resulting in death)	1	a. Due to (or a			CE CANCER					
	7) +	je	Sequentially list cond if any, leading to imm	ditions, rediate	b. Due to (or a	s a consequ	uence of):						
	cate be executed physician and the burial-transit	Examiner	if any, leading to imm cause. Enter Underly Cause (Disease or in that initiated events	njury	c								
90,	oe exe		resulting in death) La	ist	Due to (or a	s a consequ	uence of):						
8760,	physic physic the b	dical			d								
P.O. Box 6	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent p in the past 12 m 1 □ Yes 2 9 □ Unknown	nonths?	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Feta	Ideath 3□	Ectopic pregnancy	/		-	23d. Date of deliv	very Day Year
	that ned b		Part II. Other signific	ant conditions	contributing to death	but not resu	ulting in the ur	iderlying cause give	en in Part I.	23e. Dio	d tobacco u	se contribute to t	he cause of death?
rds	quires en sign uld be	ed by								_ 10	Yes 2	□ No 3 □ Pro	bably 4 Unknown
Records,	The law requir cate has been s page 2 should	Completed				· · · · · · · · · · · · · · · · · · ·				24a. Wa	as an topsy rformed?	prior to co death?	opsy findings available ompletion of cause of
of Vital	ilclan: The certificate ector, pag	BeC	25. Was case referre	d to medical	1		·		26. Place of	1 ☐ Yes Death (Check onl)	2 X No	1 ☐ Yes	2 LJNo
\	isis dir	To B	examiner? 1 ∐ Yes 2 X N	o	Hospital: 1 Inpat	ient 2 🗆	ER/Outpatien	t 3 DOA Othe)F'			Other (Speci	(fy) HOSPICE
ion o	or Attending Phatter death. Director: After the in by the funeral.	ation:	27. Manner of Death 1 X Natural 2 ☐ Accident	5 Pending investigati		jury ay, Year)	28b. Time of Injury	Work	/at ? ∕es 2 □ No	28d. Describ	e how injury	y occurred	
Division	tal or Att rs after de al Directo led in by t	Certification:	3	6 Could not determine	28e. Place of in building, e	njury - At ho etc. <i>(Specif</i>	ome, farm, stre	eet, factory, office		28f. Location City or 7	(Street and own, State)	d Number or Run)	al Route Number,
	To the Hospital of within 24 hours at To the Funeral D completely filled i	Medical	one X Nur	□ Medical Ex se Prac	Physician: To the bes aminer: On the basis titione ners	of examina	wledge, death tion and/or in	occurred at the tir restigation, in my o	ne, date and p pinion, death o	lace, and due to to	he cause(s) le, date and	and manner as place, and due t	stated. to the cause(s)
	To 1	2	29b. Signature and tit	tle of certifier	RANP			29c. License	792		29d. Dat	e signed (Month,	Day, Year)
					o completed cause of		, , , , ,	,					,
	Sta	te.	JACKIE JO 31. Date filed (Month,			ULANI Mar's Signa		EY RD.	TIMONIU	JM, MD 21	1093		
	Sta Registr				2009 Sen			and I					
DHr	VIH 17 Rev 1/2	001		U I	EUUJ JOHN	~	19	GARAGE					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** /Medical James Johnson 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5. Social Security Number BALTIMORE BALTIMORE Hesp-e Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days XXM 2 F Director 216-28-1057 81 JUL 9 1927 VIRGINIA Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, If a Medical Examination to short traumatic event, If a Medical Examination to short traumatic event, If a Medical Examination and Industrial Examinations. 28a-f show 1 ☐ Yes 2x No Directo MARYLAND BALTIMORE CO BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2660 WEST PARK DRIVE 21207 Funeral U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 45/47 1 ☐ Yes 2 XNo þ Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 2yrs T T DRIVER TRUCKING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HOWARD G THOMPSON ည ORAY FRANCE FAUNTLEROY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2660 West Park Dr., Baltimore, Maryland 21207
e of Disposition (Name of Date 20c. Location - City or Town, State Sheila L. Johnson/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 06-03-09 BALTIMORE, MARYLAND 21. Signature of where endounced william C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a. Gastric /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or impart that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? icate has l ; page 2 s certificate 2. No Division of Vital 1 ☐ Yes 2 Z No 1 ☐ Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Medical Certification: To After thi 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending te Funeral Director: A pletely filled in by the fu death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

within 2

State Registrar

completely

(Check only one)

29b. Signature and title of certifier

J. C

31. Date filed (Month)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32

9

egistrar's Signature

2310

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

02908

29d Date signed (Month, Day, Year)

2009

Leon Charles Kerwood, 3rd

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 17874

		enistrar								- 0	Date of D	oath			3. Time	or Death
	Registrar 1. Decedent's Name (First, Middle,Last)												Day Year		1700	
Exami		Leon Charles									June 1,	2009	c. County	of Death		
		4a. Facility Name (if not institution	on, give street	and number)		41	b. City, Tow Baltimo		cation of	Death		1		I/A		
		2901 Kingsley Street								0411	Data of	Bidb/AA			hplace (S	State or Foreig
uneral		5. Social Security Number	6. Sex	7. Age (I	In yrs. last bir	thday)	If Under 1 Months	Year Days	If Under Hours					Col	untry)	
irector		215-96-4184	1X M 2	F	41	Yrs.	Monuts	Days	110013		Nov	15,_	1967	Man	ryla	nd
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or items 23a or 28a-f show must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2		rmed Forces?		If Ye	es, specify (Cuban,	Mexican,	Puerto R	icán, etc.)		Whi	te, etc.		
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lygi oth	ပိ	17. Father's Name (First, Midd		1							Brew					
ental rrked	Be	Leon Charles	Kerwood	1, 11	1	9h Mailin	g Address	(Street	and Num	ber or Ru	ıral Route	Number	, City or To	own, Stat	te, Zip Co	ode)
nd Mo	₽	19a. Informant's Name/Relation					Dulan									
rages 1 and 2 shour o Entro within 12 nous survey and of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.		Jeanne MacKen	zie, io	other			sition (Name	-			Date	20	c. Locatio	n - City c	r Town,	State
permit. Pages 1 and 2 shourd be fired when 12 Department of Health and Mental Hygiene Important: If item 27 is marked other than injury or other traumatic event, the Medical injury or other traumatic event, the Medical	1	20a. Method of Disposition 1 Burial 2 X Cremati	on 3 Re	emoval from Stat		atory or ot	her place)		,	06.11	0 /00		Bolt-	imor	_ M	arylan
ages ant of nt: 1	1	Metro Grematory Inc.)3/09		Dait.	LIIIOL	e, ()	ar y raii
artme orta		21. Signature of Funeral Service Ucensee Thomas Gregor 22. Name and Address of Facility Cremation Societ 299 Frederick Ro										ryla	nd .	Inc.		
Dep Imp		74 4 4 4 1	VI .		_	29	9"Fre	der	ick l	<u>{oad</u> `	Balt	imor	e,'M	ary1		21228_roximate Inter
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ FOI	/ Department of Health		giene						
_		1 - State Registrar Certificate of Death Reg. No.?										
	Physici	an	1. Decedent's Name (First, Middle, Last)	.1	2. Date of Dea Month	Day Year						
-	/Medic	cal		cherer	June							
-	Examir	er	4a. Facility Name (If not institution, give street and number) BALTI MORE Washington Medical Ce 5. Social Security Number 6. Sex 7. Age (In yrs. las		nie	4c. County of Death Anne Arunde I by Birthplace (State or Foreign						
	Funeral Director		212-07-1990 1□M 2☒F 91	Yrs. Months Days Hour								
	pu ,		Usual Residence of Decedent									
	aryla shov	5		Town or Location		10d. Inside City Limits 1 ☐ Yes 2X No						
	the M	Director	MD Anne Arundel Glen 10e. Street and Number	n Burnie		10g. Citizen of What Country?						
	with 3a or	٥	304 Shannon Forest Court	21060		U.S.A.						
99	be filed within 72 hours after death with the Maryland stal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Profice Event, and the profiled Event.	/ Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ∑ No 1 □ Yes 2	13. Was Decedent of Hispanic If Yes, specify Cuban, Mexic 1 □ Yes 2 ☑ XNo Speci	can, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.						
21215-0036	ural",	d by	3 Widowed 4 □ Divorced Year or Dates:	TLITES ZLANO Speci	ary:	Specify: White						
15	_ 3 6	lete	15. Decedent's Education (Specify only highest grade completed)	 Decedent's Usual Occupation (Give kind of work done during m life. DO NOT use retired) 	nost of working	16b. Kind of Business/Industry						
12	thould be filed within and Mental Hygiene. marked other than " matic event, Inc. Ma	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Homemaker		Own Home						
	il Hygi other	Be C	17. Father's Name (First, Middle, Last)		other's Name (First, Middle,							
lar	should be fi and Mental I s marked of umatic eve	10 B	James Egan	E11	en May League	5						
Maryland	au s		19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street and Nun	mber or Rural Route Numbe	er, City or Town, State, Zip Code)						
	1 and 2 Health em 27		Mrs. Beverly A. Cain /Daughter			n Burnie,MD 21060						
0	9 0 - -		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	e of Disposition (Name of letery, crematory or other place)	June 6,	20c. Location - City or Town, State						
Baltimore,				raine Park Cem.	2009	Woodlawn, MD						
Ba	permit. Departr Imports any inju		21. Sometime of Funeral Service Licensee	2nd Ave. SW	Funeral & Cremation Glen Burnie, MD 21061							
		ec 19	23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line.	Do not enter the mode of dying, such	as cardiac or respiratory ar	rest, Approximate Interval Between Onset and Death						
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	scular faccio	dent	1 wook						
7	Examiner		Due to (or as a consequer	lev Arc cere	bravage	lan disese yours						
	7 -	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.									
R.	ocuted nd ransit	Examiner	Cause (Disease or injury that initiated events									
20,	ficate be executed physician and s the burial-transit		resulting in death) Last Due to (or as a consequent	ce of):								
68760,	physicate I	edical	d		-							
9 X	eath certifi attending for use as	/Me	IF FEMALE: 23c. If yes, outcome of pregnance	V		22d Date of delivery						
.O. Box	law requires that the death certil as been signed by the attending 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ 4 ☐ Pregnant at time of dea 9 ☐ Unknown	eath 3 Ectopic pregnancy		23d. Date of delivery Month Day Year						
S,	w requires that s been signed to should be deta	by P	Part II. Other significant conditions contributing to death but not resulting	ig in the underlying cause given in Par	rt I. 23e. Did to	obacco use contribute to the cause of death?						
Vital Records,	equire sen si ould b	per	Chronic renal far	ilure.	1 🗆 Y	res 2 No 3 Probably 4 Unknown						
၁၁	e law r has be	Completed	Anemia-		24a. Was autop							
=======================================	That age	Con	(Abortons so.		perfor	rmed? death? 2. ☑ 0 1 ☐ Yes 2 ☑ 0 0						
Vita	ding Physician; Th n. After this certificate funeral director, pag	ag	25. Was copie referred to medical examiner?	Calconi	ace of Death (Check only o	ne)						
of	Phys r this ral dir	5	To res 2 Band 1 Inpatient 2 ER	I/Outpatient 3 □ DOA Other: 4 □ Bb. Time of 28c. Injury at		dence 6 Other (Specify) now injury occurred						
on	nding th. : Afte s fune	tion	1 Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation	Injury Work? M 1 □ Yes 2		low injury decurred						
Division	Atter	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home bullding, etc. (Specify)		28f. Location (S	Street and Number or Rural Route Number,						
Ö	s afte	Cert	4 nornicide building, etc. (Specify)		City or Tow	rn, State)						
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.	dge, death occurred at the time, date and/or investigation, in my opinion, o	and place, and due to the death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)						
	To the within 2 To the comple	Me	29b. Signature and the of certifier Attending Physic	Ciav - 29c. License numbe		29d. Date signed (Month, Day, Year)						
				_ D4497	3.	June 2 2009						
	3		30. Name and address of person who completed cause of death (Item 23)	Ba) (Type, Print) 325 (lospoi	ilal Briver	2000 202						
	J		GURMEET-S. SAWHNEY MY	0 Glen B	unie Me	21001						
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature 33. Date filed (Month, Day, Year) 34. Date filed (Month, Day, Year)	pare								

KUCHERER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend item 28b per me g892 6-4-09 yt.
State of Maryland / Department of Health and Mental Hygiene
State of ME g892 6/16/09 IT
Certificate of Death

Reg. No. 2 0 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May **Physician** Vincent Lee Kuchinsky 31 2009 6:50 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Baltimore Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Date of Birth (Month, Day, Year) 1፟፟፟XM 2□ F Months Days Hours Min Director 213-52-3882 July 25, 59 1949 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Directo MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1338 Sargeant Street 21223 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ MNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1∐Yes 2⊠No Specify. ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Painter Painting Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be William John Kuchinsky Dorothy Dolores Corron 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela J. Kozma/sister 3645 Gray Rock Drive Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State W. Arundel Crematory | 06/02/09 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Going Monescremation Service p.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the please, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Fracture 1eft femur** Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PATHOLOGIC PRACTURE disease or condition resulting in death) WEEKS /Medical Due to (or as a covequence of): **Examiner** METASTATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Exami and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnar for in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed MUTIPLE SCLEROSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy performed? 1 ☐ Yes 2 No certificate 2 □No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Unk 28c. Injury at Work? 27. Manner of Death After 1 28d. Describe how injury occurred 5 Pending investigation 1 Natural M 1 ☐ Yes 2 🗷 No 2 Accident APRIL 27, 2009 NIGHT TRIPAND FALL Director; 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1338 SARGEANT ST. BALTIMORE, MID AT HOME e Funeral 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical tely (Check only within 2 29c License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 164395 JUNE 1,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEUE DOBERMAN, MA 6701 NORTH CHARLES ST. SUITE 4105 TOWSON, MD 21204 31. Date filed (Month, Day, Year)
JUN 0 4 2009 32. Reastrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2 Date of Death **Physician** A^{M} Elizabeth 3 2009 1:56 Loretta Kirchner June /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Dove House Westminster

If Under 24 Hrs. 8 <u>Carroll</u> 9. Birthplace (State or Foreign If Under 1 Year 8. Date of Birth (Month, Day, Jan. 1, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** ^{Year)} 1917 Months Days Hours Min Mary land 1 □ M 2 🔽 F Yrs. 92 215-32-2024 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1 □Yes 2√ No Director Baltimore Maryland Sparks 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or items 23a or USA 15908 Falls Road 21152 Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 by 1 ☐ Yes 2 ☐ No Specify: White Specify: 3 ☑ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Means injury or other traumatic event, the Means injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) 2 yrs. Organist/Piano Teacher Musician/Music 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Conrad William Ritz Jean Lean Hohman ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Falls Road Maryland 21152 William Leo Kirchner / Sparks. 15908 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Moreland Mem. Park 6/6/09 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequency of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit umine and Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 5 Other (specify) the 9 Unknown signed by t 1 be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, icate has been sig , page 2 should b 1 ☐ Yes 2 ♠No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate I 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ۴ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

2

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Sigrature

3337 Victory

29c. License number

29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			■ State	Department of Health and Me Certificate of Death	ntal Hygien Reg. N	Z 11 1 1 5 9	17878
	Dharisi		1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last)		Date of Death		3. Time of Death
	Physici /Medio	al	DOV BERNARD KLEIN 4a. Facility Name (If not institution, give street and number)			2009	5:46 A M
<u>ئ</u> ے م	Examir	er	6304 WALLIS AVENUE	4b. City, Town, or Location of Death BALTIMORE CITY	4	ic. County of Deatl	n
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bir	rthday) If Under 1 Year If Under 24 Hrs. 8. Yrs. Months Days Hours Min.	Date of Birth Month Day, Yea IAY 28, I	9. Birtl	hplace (State or Foreign
	Director		Usual Residence of Decedent		IA1 20, I	900 NL	
	/arylar f show	٥	10a. State 10b. County 10c. City, Town				10d. Inside City Limits ↓□Yes 2□No
	n the h	Director	MD BALTIMORE CITY BAL 10e. Street and Number	.TIMORE 10f. Zip Code	10g. C	Citizen of What Co	untry?
	ath wit		6304 WALLIS AVENUE	21215		UNITED S	
5-0036	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or items 23a or 28a-f show event, I'm Medical Evaniant institut at the indifficut at	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specifit Yes, specify Cuban, Mexican, Puerto Ric	y Yes or No- can, etc.)	14. Race - Ame Black, White WHI Specify:	
	n 72 ho "natul	Completed	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b.	Kind of Business/I	Industry
212	filed within Hygiene.	omo;	Elementary/Secondary (0-12) College (1-4or 5+) GE	NERAL OPERATIONS MANAG	ER	RESTAUR	ANT
Maryland 2121		To Be (17. Father's Name (First, Middle, Last) H. MANUEL KLEIN	18. Mother's Name (F		en Surname)	
	ges 1 and 2 should tr of Health and Mer If item 27 Is marke or other traumatic			o. Mailing Address (Street and Number or Rural F 304 WALLIS AVENUE, BAL			Zip Code)
Baltimore,	Pages 1 Iment of H Iant: If iten jury or oth		cemetei	f Disposition (<i>Name of ry, crematory or other place</i>) th Israel 06/03/	2000	Location - City or Sedale, N	
gai	permit. Page Department of Important: If any injury or once.		21. Signatur of Funeral Scripticen	SOL ^{am} LæVÍNSON ^{Fagility} BROTH 8900 REISTERSTOWN RO	AD. PIKE	SVILLE,	MD 21208
No.	Physician		93a: Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	not enter the mode of dying, such as cardiac or n . NFARCTION - APRE			Approximate Interval Between Onset and Death
1	/Medical Examiner		resulting in death) Due to (or as a consequence of				
		ner	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause, Disease or injury				muediate years
	xecuter and I-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	e sleep applea			years
5876U,	ificate be executed physician and is the burial-transit	edical E	d.	01).			
	certifica nding ph		IF FEMALE:		-		
C. BOX	w requires that the death certifules is been signed by the attending should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	a 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deli Month	ivery Day Year
ords, r	law requires that the death as been signed by the atter 2 should be detached for u	ρ	Part II. Other significant conditions contributing to death but not resulting in Di ABBTES MELLITUS	n the underlying cause given in Part I.		_	the cause of death?
Vital Records,	of the hospital or Attending Physician: The law no the hours after death. To the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2 sh	Completed			24a. Was an autopsy performed? 1 □ Yes 2 □	death?	topsy findings available completion of cause of 2 □ No
<u> </u>	ysiciar s certif director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Ou	26. Place of Death (Cultipatient 3 DDA Other: 4 Nursing Home		6 □Other (See	nife)
5	ng Phy		27. Manner of Death 28a. Date of Injury 28b. 1		Describe how inj		сну)
IVISION OF	r Attendi ter death. irector; A irector; A	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	M 1 □Yes 2 □No	Location (Street a	and Number or Ru	ıral Route Number,
. ב	spital o		29a. Certifier 1 Certifying Physician: To the best of my knowledge	e, death occurred at the time, date and place, and	d due to the cause	e(s) and manner as	s stated.
:	the Horn 24 the Fu	Medical	(Check only one) 2 Medical Examiner: On the basis of examination an and manner stated.				
	© <u>7</u> ₹	_	29b. Signature and title of certifier	29c. License number 0 30 3.77		Date signed (Month	n, vay, rear)
	20		30. Name and address of person who completed cause of death (Item 23a) (208 SET M. COOP EN WD 6503 PA			nus) a	21215
į	Stal Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** KRIEGER 2009 0350AM BLANCHE June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltmone Northwest HOSPITAL Randallstown Cente 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day DEC 20 6. Sex **Funeral** 1 ☐ M 2 🗷 F T925 NEW YORK 131-14-7933 83 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Exercit ner I wat be notified at Director 1 ☐ Yes 2 🙀 No MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21117 USA 4730 ATRIUM COURT #302 "natural", or items 23a by Funeral . Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 👿 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: WHITE 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "n any hijury or other traumatic event, the Med once. Elementary/Secondary (0-12) 12 College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROSENFELD SARAH MOSKOWITZ မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9905 MIDDLE MILL DRIVE OWINGS MILLS, MD 21117 CHARLOTTE HIRSCHBEIN/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HAR SINAI 06/03/2009 OWINGS MILLS, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Scrt 8900 REISTERSTOWN ROAD - PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a Atherosclerotic Coronany disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by (enal 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 👿 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🗷 No 2 No 1 ☐ Yes certific 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital Other: 4 \sum Nursing Home 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ★ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide To the Hospital o within 24 hours To the Funeral 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State Registrar 29b. Signature and title of certifier

The

31. Date filed (Month, Day, Year)

Christ

Old Count Rd

00057634

Randallstown, MD

29d. Date signed (Month, Day, Year)

2009

and manner stated.

5401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brand mD

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09-04365 Barry Lippard Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of Maryland /	Department of He	alth and	Mental	Hygiene

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		or State											3. Time of Death					
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Funeral	5.	Social Security N		6. Sex		7. Age (In yrs	s. last birt	thday)	If Under 1	Year	If Under	_	8. Date of E	irth (MN	W/DD/YYYY	g, Bir	rthplace (State or Fountry)	oreign
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with the ns 23a se noti		1. Marital Status			12. Was De	cedent Ever in	ı U.S.	13. Was	Decedent es, specify	of Hispa	anic Origir Mexican, I	n? (Spe	cify Yes or Nican, etc.)	No-		- Ame e, etc.	rican Indian, Black	,
215-0036 be filed within 72 hours after death with the Maryland mal Hygione. The dother than "natural", or items 23a or 28a-f show any cut, the Medical Examiner must be notified at once.	1	Never Marri		- 1	Armed F	2 X N	0	1							Specify:	Whi	ite	
	5	Widowed 15. Decedent's E			or Dates:) 16a	Decedent	Yes 2	cupatio	n (Give ki	nd of wo	rk done	16b	. Kind of Bu			
5-0036 ed within 72 hours tygiene. other than "nature he Medical Exan	<u> </u>	Elementary/Sec				1-4 or 5+)		during mo	ost of worki	ng life. I	DO NOT u	se retire	d)					
136 thin 7. than than edical		,				4	M	anage	er						I.R.S			
5-00 led wi Hygier other		7. Father's Name								1					en Surname)		
21215-0036 uld be filed within 72 hours after Mental Hygiers marked other than "natural", cevent, the Medical Examiner		Brent L 9a. Informant's N			(ne Print)		19	9b. Mailing	Address	(Street			eters		, City or Tov	vn, Sta	te, Zip Code)	-
MD 21215-003 42 should be filted within the and Mental Hygiene. In 27 is marked other th unmatic event, the Med		Mrs. Cat				Wife pard /		8133	Windy	y Fi	le1d	Lane	Mill	ers	ville,	, MI	21108	
5 7 4 4	- 1	0a. Method of Dis	position			2	0b. Place	of Dispos	ition (Name	of cem	netery,	Tun	Date e 7,	20	c. Location	- City	or Town, State	
Baltimore, Permit Pages I and Department of Healt Important: If item injury or other training.	'	Burial 2 Donation			Removal	from State		ntic	Crema	ator	y	20	09	G.	len Bu	ırn:	ie, MD	-
Baltin permit. P Departme Importar injury or	2	1. Sime ture of F	uneral Service	e Licens	see			22. N	Name and A	ddress	of Facility	Sing	leton	Fu	neral	& (Cremation	1 1061
Pag Pag Tili		Services, PA 1 2nd Ave. SW G1er a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock													Approximate			
Physician dical	P	3a. Part I. Enter t failure. List o	he disease, nly one cau	se on ea	ch line.								, ,				Between Ons Death	
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Box 687 ne death certific	icia 	past 12 month		Jnknowr		gnant at time	of death	5 0	ther (Spec	ify)								
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Division pital or Attendii ous after death.	Certification:	3 Suicide	d	ould not	be		- At nome	e, tarm, su	eet, factory	, onice	bulluling, c			wn, Sta				
Hospital 24 hours Funeral tely filler		4 Homicide	-				owledge,	death occ	urred at the	time, d	ate and p	ace, and	due to the	cause(s) and man	ner as	stated.	
Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certiff within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical	(Check only one) 2	/ Medical I	Examine	er:On the ba	sis of examina	tion and/	or investig	ation, in my	y opinio	n, death o	ccurred	at the time,	date an	nd place, all	u uue i	to the cause(s)	
T vivi	ğ	29b. Signature a	nd title of ce	rtifier	grid marile				29		se numbe	001	ME	1			(Month, Day, Year)	ı
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20	ı	30. Name and ac							111 D	enn c	treet R	altimo	e, MD 2	1201				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Thomisena Lundy 5:50p. 2009 06 01 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Terrace Baltimore 2137 Cheslea If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Min. Months Days Hours 1 □ M 2 □ F 220-22-2926 SC 90 01 18 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 K⊋Yes 2 🗌 No Director Baltimore NA MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21216 Funeral 2137 Cheslea Terrace Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married 1 ∐Yes 2**X** No Specify: þ Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Domestic Worker permit. Pages 1 and 2 should be file. Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatical once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lyda Jordan ပ္ Alonzo Jordan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2137 Chelsea Terrace, Baltimore, Md 21216 Charlie Lundy-Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/5/09 Crownsville, Md Crownsville Vet. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore, Md Thompson 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CARDIAC AnnyHTHMIN 5000 CN **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 7 EARS ASCUD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav 4 ☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by filled in by the funeral director, page 2 should be DEMENTIA 2 No 3 Probably 4 Unknown 1 ☐ Yes certificate has been MALNOUM'SH MENT 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No HONA TION 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2⊡No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation ◆ ☐ Natural 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Maryland 21215-0036

Baltimore,

P.O.

Division of Vital Records,

State Registrar 31. Date filed (Month, Day, Year)-

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



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			For State	State of Maryla		ertment of H			000	0 17002
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	uncate of L	- Call	2. Date of Dea		3. Time of Death
-1000	Physici /Medic		VELESTER		LA	THROP		Month	30 Jou	9 5:21 #
	Examin		4a. Facility Name (If not institution, give s The Johns Hopkins Ho			4b. City, Town, or Baltimore	City		4c. County of De	
Antigue "	Funeral Director		3/4-88-1642	M 2X F 7. Age (In y	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Day	h y, Year) 9.1 .6 66	Birthplace (State or Foreign Country) M I
	and ow		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	: Mary a-f sh fied a	ctor	VA NA		P	ldie				1 ☐ Yes 2X No
	vith the a or 28 be noti	Director	10e. Street and Number	an Causio		10f. Zip-Code	20105		10g. Citizen of What	Country?
	iges 1 and 2 should be filed within 72 hours after death with the Maryland not Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Funeral	TTT Marital Clates	Was Decedent Ever in Armed Forces?	13. \	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Specify Yes or No- to Rican, etc.)		nerican Indian,
9600	ours afteral", or Examin	þ	1 Never Married 2X Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:		I ☐ Yes 2 🛣 No	Specify:		Specify:	Black
21215-0036	hin 72 h In "natu Medical	Completed	15. Decedent's Educify only highest grade Elementary/Secondary (0-12)		(Give	lent's Usual Occup kind of work done o OO NOT use retired,	during most of we	orking	SAIC GOV	,
21	ed with	Con	12th grade 17. Father's Name (First, Middle, Last)	4yrs	Prog	gram Man		ama (Firet Middle	Contract , Maiden Surname)	or
Maryland	uld be fil fental H rked oth ic even	To Be	Paul Phifer					ret M.		
lary	2 shou and M is mai	- 5	19a. Informant's Name/Relationship (Typ	•			and Number or F	Rural Route Numb	er, City or Town, State	
e, r	1 and Health em 27 ther tr		Michael Lathrop 20a. Method of Disposition		b. Place of Dispo	sition (Name of	- 1	Date	20c. Location - City	or Town, State
mor	Pages ent of nt: If it		1 XBurial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, crer	natory`or other plac of Heave		6/09	Silver	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other		21. Signature of Funeral Service License		M ²	Name and Address	s of Eacility		imore, Mo	주 토
			23a. Part . Enter the disease, or complication shock, or heart failure. List only on	cations that caused the d						Approximate Interval Between
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3760,	te be e ysician he buri	dical								
x 68	certifica ding ph use as t	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pre					23d. Date of	delivery
P.O. Box	or Attending Physician: The law requires that the death certificate be executed sifer death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown	1 Live birth 2 4 Pregnant at time 6		Ectopic pregnancy Other (specify)	/ 		Month	Day Year
ds, P.	uires that I signed by	δ	Part II. Other significant conditions con	tributing to death but not	resulting in the u	underlying cause gi	ven in Part I.	23e. Did t	. /	e to the cause of death? Probably 4 Unknown
eco	law req as been e 2 shou	Completed	·	-				24a. Was autop		autopsy findings available to completion of cause of
<u> </u>	sician: The certificate h irector, pag		25. Was case referred to medical				26 Place of De	1 ☐ Yes	2 No 1	Yes 2 □ No
₹	ysician: s certifica director,	To Be	evaminer?	lospital: 1X Inpatient	2 🗌 ER/Outpatier	t 3 DOA Othe	or:	Home 5 Resid		pecify)
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Division of Vital Records,	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - A building, etc. (Spe			Yes 2 No	28f. Location (City or Tox		r Rural Route Number,
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	To the Hospital within 24 hours of the Funeral Completely filled	edical	one)	ner: On the basis of exam and manner stated.	nination and/or in	vestigation, in my o	pinion, death oc	curred at the time,	, date and place, and	due to the cause(s)
_	To the within 2 To the comple	Σ	29b. Signature and title of certifier	Q. 11Cx .o.	¥	29c. License	e number		29d. Date signed (M	
			30. Name and address of berson who co	mnleted cause of death	(Item 23a) (Type.	Print)			MAY, 30	
			DEEPA RANGACHA	RI STOHNS	HOPKIN	K HOSPI	TAL 600	North Wo	olfe St, Baltin	more, MD, 21287
	Sta Registi		31. Date filed (Month, Day, Tear) JUN 0 4 200	32 Registrar's Si	gnature.	uke				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

		1- For State Registrar Certificate of Death Reg. No. 2009 7	88
Physic Medical Exam	an/ iner	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year	th
find	•	Betty Ann Lambie May 21, 2009 1/44 nrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
		1208 West 36th Street Baltimore	
Funeral Director		5. Social Security Number 1	unk
any		Usual Residence of Decedent 10a. State	Limits
rland -f show	tor	Baltimore 1 X Yes 2	No
h the Mary 33 or 28a	I Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1208 W. 36th Street 21211 USA	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show any atte event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc.	Κ,
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T = 0 = 3	o Be		dirk
	Ĕ	19a. Informant's Name/Relationship (Type, Print) O.C.M.E. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Penn Street Baltimore, MD 21201	
ore, M ssland 2 of Health If item 2		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 Burial 2 Cremation 3 Removal from State crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place)	
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other tr		4 Donation 5 X Other Specify: in state	
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		Sequentially list conditions, b	
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O. Bo It the de by the a	ا≨	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of deat	h2
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Division tal or Attendir rs after death. al Director: A	Catio	2 Accident Investigation 1 Yes 2 No	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Certification:	3 Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)	, City
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To the within 2 To the complet	ᄝ	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month Day Year)	
	-	29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 29, 2009	
		30. Name and address of person who completed cause of death (Item 23a)	\neg
Str	ate	Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature	
Regist	_	JUN 0 4 2009 Gener S. Jako	

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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r	4a. Facility Name (If not institution	n, give street and n	umber)				ocation of Deat	h	1		y of Death					
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	5. Social Security N	Numberulik	6. Sex 1 ☑ M 2 ☐ F		yrs. last birth	rs. Months		If Under 24 Hrs Hours Min.	(Month, Da	tn i <i>y, Year</i>	20	9. Birti	hplace (State untry)	u 1			
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	10a. State	10b. County		100	c. City, Town	or Location							10d. Inside	City L			
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	20a. Method of Dis				0b. Place of D	Disposition (Nai	me of other place))	Date	20c.	Location	- City or	Town, State				
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	4 □ Donation 5 X Other (Specify) in state 21. Signafure of Funeral Service Licensee.																
	Ronald S. Wade, Director State Anatomy Board 655 W. Baltimore Street																
-	3a. Par 1. Enter	the disa se, or	mplications that	caused the		Baltimore, MD 21201 23a. Par 1. Enter the discusse, or amplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,											
		shork, or heart fail fre. List only one cause on each line.										Approxim					
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Maenner JUNT 7 2009 4b. City, Town, or Location of Death 4c. County of Deat 4a. Facility Name (If not institution, give street and number) timore Washington Burni (F Med Conte thne e M Date of Birth (Month, Day, Yea Jan. 15, If Under 1 Year | If Under 24 Hrs. 6. Sex 2 F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Months Days Hours Maryland 1943 218–40–4298 Usual Residence of Decedent 66 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No Anne Arundel Pasadena Maryland 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code U.S.A. 21122 225 Falcon Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 █ No Specify Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Concrete Company Salesman 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Т. Maenner Loretta Walczak John 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 225 Falcon Drive Pasadena, Maryland 21122 <u>Paulette E. Maenner (Wife)</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 06/02/09 Baltimore, Maryland Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryla<u>nd 21122</u> 23a. Part 1. If ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):

Physician /Medical Examiner

Department of Health Important: if item 27 any injury or other tronce.

Physician

Examiner

Funeral

Director

death with the Maryland to be notified at

Pages 1 and 2 should be filed within 72 hours after death wiment of Health and Mental Hygiene.
ant: if item 27 Is marked other than "natural", or items 23a ury or other traumatic event, it a feath and it is in a to item.

Baltimore, Maryland 21215-0036

Maenner

/Medical

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Director

Funeral

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Completed

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Be Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be execute attending physician and for use as the burial-tran cate has been signed by the a page 2 should be detached to

certificate Medical Certification: To within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

Division of Vital Records, P.O. Box 68760, 区

cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of): d.				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month Day Year			
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown			
		24a. Was an autopsy performed? 1 □ Yes 2 No 1 □ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No			
25. Was case referred to medical examiner?	26. Place of Dea	ath (Check only one)			
examiner? 1 No 2 No	Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing H	Home 5 ☐ Residence 6 ☐ Other (Specify)			
27. Manner of Death Natural 5 Pending investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred			
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) Certifying Physics Medical Exem	ysician: To the best of my knowledge, death occurred at the time, date and place iner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)			

29c. License number D65911 29d. Date signed (Month, Day, Year)

June 1 2009

Tlen Burnie 21061

10

State Registrar 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) atnakav

29b. Signature and title of certifier

Mukheriee 31. Date filed (Month, Day, Year)

32, Registrar's Signature JUN 0 4 2009

To the Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Day **Physician** Jane M. Marsh 2:30 a M 2009 June 2nd /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Gilchrist Hospice Baltimore Towson 5. Social Security Number 6 Sex f Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🕅 F 21,1952 Director 217-52-3389 58 April Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☑ No MD Howard Ellicott City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3052 Hickory Mede Court 21042 Funeral United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 ☐Yes 2**XX**No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygie
Important: If item 27 Is marked other tt
any injury or other traumatic event, the Entrepreneur <u>Automotive</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emory McGarrigle Helen Gadow 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Marsh 3052 Hickory Mede Court; Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 6/3/09 Glen Burnie, MD 22. Name and Address of Facility Funeral Home of Signature of Funeral Service Licensee License Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, solidate Cause (Final Ca Approximate Interval Between Onset and Death 23a. Fart 1. Enter the disease. Immediate Cause (Final **Physician** reas Months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Vear Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOSPLU 1 Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar N. Charl

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year MITCHELL **Physician** 0842A 5CAR 200 16 MX' /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number, Examiner MUERSITY BALTIMORE MARYCAND 02 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. **X** M 2□ F Yrs. 3/01/1944 Murphy, Miss 428-84-5074 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Sem 27 is marked other than "natural", or items 23a or 28a-f show wher traumatic event, the Medical Examination and be relitied at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Yes 2□No **Funeral Director** Prince Georges | Capital Height's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20743 703 62nd Avenue 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2√ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Specify:Black 1 □Yes 2 No Specify. Be Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Park Service <u>Land scaping</u> 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Darris Welch Marvin Mitchell ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 703 62nd Ave., Capital Height's, MD. 20743 Regina Robinson/daughter permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 1/09 HESAPROKE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 420 H StreetNE Nenu B.K. Henry Funeral Home Wash.DC.20002 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of ach line. Immediate Cause (Final disease or condition resulting in death) THENOSCLERO TIC CARDIOVASCULAR **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine ORONAR To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and physician and s the burial-trans as a consequence of) Due to #6 Physician/Medical If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the enderlying pause given in Part I. ACUTE DIALYSIS DEPENDENT ENTRY 4 Unknown FAILU 1 🗌 Yes 2 🔲 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? GENIC 24a. Was an autopsy performed? SEPSIS 1 ☐ Yes 2 | No 25. Was case referred to medical examiner? 1 Yes 2 □ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? (Month, Day, Year) 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Maryland 21215-0036

Saltimore.

Box 68760

P.O.

Records,

Division of Vital

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29a. Certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death

31. Date filed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death JUNE 2009 9:25F M Joseph McCullough 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Saint Joseph Medical Baltimore If Under 1 Year | If Under 24 Hrs. . Sex M 2□F 8. Date of Birth (Month, Day, Year) 1–10–1948 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 247-82-8470 Yrs S.C. 61 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1√2Yes 2□No MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Dame Lane Apt

12. Was Decedent Ever in U.S.
Armed Forces?

1 Yes 2 7 No
If Yes, Give Year or Dates: USA 104 21212 Notre 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married X ☐ Married 1 □ Yes 2√CXNo Specify. Specify. Blck 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 9th grade N/A18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frederick McCullough Drucell 19a. Informant's Name/Relationship (Type. Print) Wife Maria Talley McCullough 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21212 431 Notre Dame Lane Apt 104 Balto, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Marial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Cemetery 6-8-2009 Balto, MD 21. Signature of Fureral Service Licens 22. Name and Address of Facility March East F/H 1101 E. North Avenue MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Last only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition METASTATIC PROSTATE CANCER resulting in death) Due to (or as a consequence of) ACUTE RENAL FAILURE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Dav Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? autopsy perforn 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Mariner of Death Time of 28d. Describe how injury occurred Injury at Work? 5 Pending

1 □Yes 2 □No

be basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner Examiner

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Physician/Medi

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Certification:

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nd Mental Hygiene. marked other than

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permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any Injury or other traum

72 hours after

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-trar the is been signed by the should be detached this certificate has al director, page 2 s After

Box 68760,

P.0.

Division of Vital Records,

requires that the death certificate be executed

The Hospital or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 5

> State Registrar

KHOSROW 31. Date filed (Month, Day, Year) JUN 0 4 2009

2 Accident

3 Suicide

4 Homicide

(Check only

29b. Signature and title of certifier

one)

30. Name and add

7621 TABASSI M. D. 32. Registrar Signatu

investigation

2☐ Medical Examiner:

6 Could not be determined

ess of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE TOWSON. MARYLAND 21204

🖟 Certifying Physician: To he best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License numbe D46356

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 19a, per Int 6892 6/9/09 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 6:00 AM M 31 2009 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel <u>Anne Arundel Medical Center</u> Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept 29 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 □ F 578-38-7919 78 Sept Maryland Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show if Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Worldal Examinat must be no filled at MD Anne Arundel 1 ☐ Yes 2 No Director Gambrills 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any highy or other traumatic event, the Modean Expension once. 10e Street and Number 2468 Bell Branch Road 21054 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2X No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) truck driver transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James C. McKenzie Agnes Regina Beathey ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helene Morelane/friend Helena M. Moreland 470 W. Dares Beach Road Prince Frederick, MD 20678 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Ronal Popular Sicense ade ²²State Anatomy Board 655 W. Baltimore Street Director 21201 Baltimore, MD 23a. Part L Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 124mon **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a sonsequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ___mpatient 2 ER/Outpatient 3 DOA 1 Yes Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 😭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature 5/31/2009 12M354 30. Name and address of completed cause of death (Item 23a) (Type, Print) esnick

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State

Registrar

31. Date filed (Month, Day,

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Funeral		5. Social Security Number	6. Sex	7. A	ge (In yrs. last	birthday)	If Under 1	Year If Under Days Hours	Min. 8. D	ate of Birth(M	WUUUITT	Foreign	m MARYLAND
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21215-0036 Uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho c event, the Medical Examiner must be notified at once.		11. Marital Status	12. W	as Decede	nt Ever in U.S.	. 13. Wa	s Decedent	of Hispanic Orig Cuban, Mexican,	in? (Specify	Yes or No- . etc.)		ace - Ameri /hite, etc.	ican Indian, Black,
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21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	Be	ROBERT MONTG	OMERY			40h Mailin	a Addross	(Street and Nun	SETTA I	MONTGOL Route Numbe	r. City or	Town, State	e, Zip Code)
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiewier man: If item 27 is marked other than "matural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	P L	19a. Informant's Name/Relatio											- 1
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no Pages ent o int: I		4 Donation 5 Other		_	KIN	IG MEMO	RIAL	PARK	06-08	-09 L	BALT:	IMORE	, MARYLAND
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum		21. Signature of Frinch Serv	Licensee			TA7 7	T.T.TAM	ddress of Facilit	N COMM	UNITY	FUNE	RAL H	OME P.A.
E Per E			Suoi	w									Approximate Interval
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Division of Vital Records, P.O. rel or attending Physician: The law requires that the state death. The law receives the this certificate has been signed by an Director. After this certificate has been signed by the chief.	a a		dical	tal:		ER/Outpation		Other:			Residence	e 6 🗸 O1	ther: Scene
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ivisior I or Attend after death Director:	1	3 Suicide 6	Could not be				tieet, lactor	,, 0.1100 2011-1119		or Town, S '00 Block of	latel		
Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physical forms and the stronger of	Cortification.	4 Momicide	determined		Parking L	dee dooth or	courred at the	e time, date and	place, and di	ue to the caus	e(s) and i	manner as :	stated.
e Hos	letely		ng Physician: Examiner: On	To the best the basis of	t of my knowle of examination	and/or invest	igation, in m	y opinion, death	occurred at t	he time, date	and place	, and due t	to the cause(s)
To the Hospital within 24 hours	complete	one) 2 Medical 29b. Signature and title of c	and	manner st	ated.			c. License numb			29d. Da	ate signed	(Month, Day, Year)
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H.		30. Name and address of po	erson who com	pleted caus	e of death (Ite	m 23a) 1 Penn St	reet Ralf	imore, MD 2	1201				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9:00 M June 2009 DENISE MILLER 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death UPPER CHESAPEAKE MEDICAL CENTER BELAIR HARFORD CO If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Days Hours Months 1 □ M 2X F NOV. 5 1961 NEW YORK 052-58-0130 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 1 TYes 2XXVo **EDGEWOOD** HARFORD CO MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21040 U.S.A. 1305 CEDAR CREST CT. 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes XXNo Specify: SpecifyBLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) HOUSEWIFE N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ELLA EVANS DAVID OLIVER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1305 CEDARD CREST CT., EDGEWOOD, MD 21040 Keith Miller/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XIX Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) MT. PLEASANT CEMETERY 06-06-09 HAWTHORNE, NEW YORK 22. Name and Address of Facility
WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, P
321 S PHILADELPHIA BLVD., ABERDEEN, MD 21001 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MUSCARSIAL INFARCTION NOOP! Due to or as a consequence of): CONDESTIVE HEART FRILUDE Due to (of as a consequence of, HYPERTENSION Due to (or as a consequence of) MON CHROMAN DEPENDENT DIMETER 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner ysician and le burial-trans

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Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner?
1 ★ Yes 2 No 27. Manner of Death 1 Natural 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c, License number Order Helico mo 10050103 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year) ----

HAWKERD NO 602 SOTTH ATTUODE RO INITE 101, SEL AIR, no Yoly

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day **Physician** THINE Gerald Lee Martin 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Center Towson Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Hours 1√ M 2□ F Maryland 218-40-4531 66 Nov. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Baltimore Baltimore 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number with. items 23a 21234 USA 6804 Collinsdale Road Funeral 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Wes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 'natural", or 1 □Yes 2 □**Y**No Specify \$ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: white Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher and Coach permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygin Important; If item 27 is marked other any injury or other traumatic event, It 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ottis Jefferson Martin Edith Leona Bull 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6804 Collinsdale Road; Baltimore, MD 21234 Ruth P. Martin wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🗆 Burial 2☐ Cremation 3 ☐ Removal from State 5 NOther (Specify)entombment 6/5/09 4 Donation Overlea, MD Gardens of Faith 21. Signature o Fin 7 Se 22. Name and Address of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final CARDIOGENIC SHOCK **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner RESPIRATORY FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of ACUTE MYOCARDIAL INFARCTION ng physician and as the burial-tran Due to (or as a consequence of) P.O. Box 68760 CORONARY ARTERY DISEASE Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ RENAL FAILURE 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed LACTIC ACIDOSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe certificate 1 ☐ Yes 1 ☐ Yes of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death
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2 □ Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? he Hospital or Attending Pin 24 hours after death.
he Funeral Director: After to pletely filled in by the funeral 28d. Describe how injury occurred After Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 17 crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier m> 6-1-09 D31826 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD LINTHICUM M. D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 0 4 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Mary Ellen Newman 2:11 100 200 4c. County of Death City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Saltimore If Under 1 Year | If Under 24 Hrs. tê a 9. Birthplace (State or Foreign 8. Date of Birth Sept. 9, 5. Social Security Number (In yrs. last birthday) 7. Age , 1920 Maryland Days 1□M 2 🕇 F Min. 88 218-18-9279 Yrs Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 XNo Catonsville Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21228 5741 Edmondson Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 X Never Married 2 ☐ Married White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Esthetician Cosmetic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ellen McConnell Otto J. Newman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5925 W. Roland Avenue; Littleton, Colorado 80128 Elizabeth Scales Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 6/4/2009 Glen Burnie, Maryland Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilinSterling Ashton Schwab Witzke 21077 21. Signature of Funer Funeral Home of Catonsville, Inc. MO1537 MD 21228 1630 Edmondson Avenue; Catonsville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lour ACUTEMYOCARDIAL INFARCTION disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to himediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 ☑ 📉 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 4 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☐ 1√0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Evantmer and by notified at

Baltimore, Maryland 21215-0036

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of Vital Records, P.O. Box

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Physician: s after death.

I Director: After this c or Attending filled in by To the Hospital c within 24 hours af To the Funeral D

> 6 State Registrar

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Certification;

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29a, Certifier (Check only one) 29b. Signature and title of certific

and address of persor

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

D 2267 who completed cause of death (Item 23a) (Type, Print)

MAY 30, 2009

- SNYDER mo 900 SOUTH CATON AVENUE BALTIMORE MANYLAMD 21229 31. Date filed (Month, Day, Year) 32.

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		1 - For Amend Items 236	ate of Maryland	29de3 Ce	rtificate of	nealth and 78 - 8892 Death			2009	9 1789	
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Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 24 H	rs. 8. Date of Bi	rth ,	9. Bir	rthplace (State or Foreig	
Director		216-72-1765 ¹™™	^{2□ F} 50	Yrs.	Months Days	Hours Mi	Jan 28	3, rear)	59 Mar	yland	
pu »	1	Usual Residence of Decedent 10a. State 10b. County	100 City	, Town or Lo	ention					10d. Inside City Limits	
filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the modical Erah, more ustor redifficed and	5									1 ☐ Yes 2 ☐ No	
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a or	흐	10e. Street and Number 14124 Whispering Pin	o Court		10f. Zip Code	0690			izen of What Co USA	ountry?	
is 23	eral		as Decedent Ever in U.S	2 12			(Specify Ves or N		14. Race - Am	erican Indian	
ral", or items 23a or 28a-f show Fran increust be notified at	by Funeral Director	1 Never Married 2 Married 1 If	rmed Forces? ☐Yes 2 M No Yes, Give ear or Dates:		Was Decedent of H If Yes, specify Cub 1 □Yes 2X No	Specify:	erto Rican, etc.)	0-	Black, Whit		
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is m		19a. Informant's Name/Relationship (Type. P Betty Morgan/siste		1	ng Address <i>(Street</i> Marlboro						
thert				<u> </u>			Date Capi			<u></u>	
Important: If item 27 is marked other any Injury or other traumatic event, <u>once.</u>		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remov 4 ☐ Donation 5 🖾 Other (Specify) 11	state		osition (Name of matory or other pla	1			ocation - City or		
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sician edical miner	er	shock, or heart failure. List only one can immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to immediate	use on each line. Due to (or as a conseque) Due to (or as a conseque)	ontro	prost	ate Co	ancer		_	Approximate Interval Between Onset and Death	
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To the Funeral Director: completely filled in by the	Medical		on the basis of examination manner stated.	ion and/or ir	vestigation, in my	opinion, death oc	curred at the time	, date and	d place, and du	e to the cause(s)	
P 8	-	29b. Signature and title of certifier			29c. Licens	se number 06 80°2	6		te signed (Mon		
		Vous MJ				10002	.0	Jun	e 3, 20	1U9 	
		30. Name and address of person who comple Padmaja Bandi, MD, N				1					
Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signati								
Registr	ar	JUN 0 4 2009	River A	ha	Kel						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 Month Day 2116 PM May James 25 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1**X**M 2□F Days Yrs. -29-1925 220-14-1045 miD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits 1 Yes 2 □ No MID BAITIMUR 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country 3006 2/2/3 U.S. A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes Give Year or Dates: 1945 1 ☐ Yes 2 No Specify. Specify: Black 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Bethelhem Steele Elementary/Secondary (0-12) College (1-4 or 5+) CORPORATION worken 100 3 rd Nonc 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Thorton Jessie Thomas 19a. Informant's Name/Relationship (Type. Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MAXINE Wedington 3006 & FERDENST, BATTO. MD. 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CARRISON Forest WA. 22. Name and Address of Facility Owings Mills m) June 4, 2009 21. Signature Fureral Service Licensee BOTTS Funexal HOME BOTTS FUNEXAL HOME AND THE ST. ST. BAITINO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmona Hypertension disease or condition resulting in death) honic Pistmono if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 2 No Yes 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 🗌 Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 2 No 2 ER/Outpatient 3 □ DOA 6 Other (Specify) 27. Manner of Death 28c. Injury at Work? 1 ☐ Yes 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 1 Natural 5 Pending (Month, Day Year) Injury

Examiner Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician: The law requires that the death certificate be executed ector, After I Director: A od in by the f within 24 hours completely

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Department of Health and Mental Hygiene. Important: friem 27 is marked other than "natural", or items 23a or 28a-f st any injury or other traumatic event, the Medical Examiner must be notified one.

Physician

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Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

with the Maryland

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ation:	27. Manner of Death 1 Manual 5 Pending 2 Accident investigation	ation	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ury occurred			
Certification:	3 Suicide 6 Could n 4 Homicide determin		ome, farm, street, factory)	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
dical		Physician: To the best of my know examiner: On the basis of examination and manner stated.				(s) and manner as stated. nd place, and due to the cause(s)			
Me	29b. Signature and title of certifier		. 2	29c. License number	29d. Da	29d. Date signed (Month, Day, Year)			
	Zommor	Grippi	a.M	RES 000	Ma	ay 26 2009			
	30. Name and address of person v	ho completed cause of death (Ite	m 23a) (Type, Print)						
	Sommer Gr	19995		600	North Wolfe S	St, Baltimore, MD, 212	87		
te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature /						
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Registrar

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Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

Box 68760, the P.O. ò Division of Vital Records, this certificate

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 4:15 Pm Richard Patrone **Physician** J. June 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1126 Wilson Ave. Baltimore Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
March 25,1950

9. Birthplace (State Country)
New York 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 X M 2 □ F 269-42-5708 59 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shov any Injury or other traumatic event, the Medical Examiner must be notified at Baltimore 1 ☐ Yes 2 No Director Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21207 1126 Wilson Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 M Married White 1 ☐Yes 2 No ò Specify 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Coal Mining Coal Miner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Talkington Samuel Patrone ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1126 Wilson Avenue; Baltimore, MD 21207 Wife Rosemary Patrone 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【S Cremation 3 ☐ Removal from State 6/6/2009 Glen Burnie, MD 4. Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. Signature of Funeral Service Danielle 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part 1. Enter the disease, omplications that aused the atheshock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) eus. Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 1 Tyes 2 TNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe 2 No 2 No 1 □Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 \textbf{\textit{M}} Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural within 24 hours and war.

To the Funeral Director: After a smaller of the funeral part of the fur 5 Pending investigation 1 Tyes 2 🗌 No 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check onl and manner stated 29b. Signature Name and address of perso who completed cause of death (Item 23a) (Type, Print) 405 Frederich Road 31. Date filed (Month, Day,- Year) --State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 0050 JUNE 2009 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) BALTIMORE WASHINGTON NEDICA ANNE A CURNIE ENTER GLEN Sex 1 M 2 □ F Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday, Days Hours Year Months 212-26-7642 80 Feb. 4, 1929 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Anne Arundel Co. Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 24 Main Avenue, SW 21061 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11, Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates: Korean 1 ☐ Yes 2X No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 yrs. Mechanic Automotive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Julia Arold John Elijah Parks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Agnes W. Parks / Wife 24 Main Avenue, SW Glen Burnie, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Glen Haven Mem. Park | 6/6/2009 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Singleton Funeral & Cremation M01121 Services PA; 1 2nd Ave. SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hours Myocardia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☑ No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Physician /Medical Examiner P.O. Box 68760, Division of Vital Records, al or Attending Patter death.

I Director: After din by the funera To the Hospital within 24 hours a To the Funeral D

cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit

After this

completely filled in by

Physician

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Certification: To

Medical

29a. Certifier

(Check only one)

30. Name and add

301

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it is Medical Examinat must be notified at

n and Mental Hygiene.

bermit. Pages 1 and 2.
Department of Health an.
Important: If item 27 is m.
any injury or other

Saltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

Registra

, Glen Burnic, MD

ss of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Drive

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

H0068605

29d. Date signed (Month, Day, Year)

June 2. 2009

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			Registrar			Ce	rtificat	e of L	Death			g. No. 💪 U U	0 1 1000
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9	/Medic	al	4a. Facility Name (If not institut.			000-1	4h City	Tour or	Location		5	4c. County of D	
1	Examin	er	Riverview Reh					Essex		OI Death		Baltin	
	Funeral	-	5. Social Security Number	6. Sex	7. Age (I	n yrs. last birthday) If Under	1 Year_	If Under	r 24 Hrs. 8. D	ate of Birth Jonth, Day,		Birthplace (State or Foreign Country)
	Director		190-12-4147	1 □ M 20	S F	85 Yrs.	Months	Days	Hours	Min. (A	3-09-	19 24 Per	nnsylvania
	put		Usual Residence of Decedent 10a. State 10b. Coun	tv	11	Oc. City, Town or I	ocation						10d. Inside City Limits
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	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or items 23s or 28a-f show afte event. The Medical Exafricact, out to indiffied at	Funeral Director	11. Marital Status	12. Was	Decedent Eve ed Forces?	er in U.S. 13	. Was Dece	dent of Hi	ispanic Or	rigin? (Specify `	Yes or No-		American Indian, Vhite, etc.
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פ	e filec Il Hyg othe vent.	BeC	17. Father's Name (First, Middl	ə, Last)					18. Moth	ner's Name (Firs	st, Middle, N	Maiden Sumame)	
<u> a</u>	Wenta Wenta arked	ToE	John B. Gatt	on					Gra	ce Bell	Curr	ent	
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	l and lealth im 27 her tr		Jo Jones/nied	.e		20b. Place of Disp			ring	Date Date	-	ore, MD	21234
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28a-f show amy injury or other traumatic event. The Medical Examination and be maillised at ADGG.		20a. Method of Disposition 1 Burial 2 Cremation			cemetery, cr			e)	Date		200. Location - Oil	y or rown, State
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77			23a. Part LEnter the disease, shock or heart failure. L	or complications	that caused th	e death. Do not e	nter the mod	nore te of dyin	g, such as	21201 s cardiac or res	piratory arre	est,	Approximate Interval Between
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			Howard County Ge				Colum				vard	
	Funeral Director		5. Social Security Number 6. 217–16–5867	Sex 7.7 1 M 2 □ F	Age (In yrs.	last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	Hrs. 8. Date of Birt Month, Da March 2	h V. Year) 4. 1921	_ Cou	place (State or Foreign ntry) Vland
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			30. Name and address of person wh Nishi Rawat M.D.	10724 Li	ttle I	Patuxer	it Parkway	Room	200 Colum	nbia, MD	210	44
I	Sta Registr		31. Date filed (Month, Day, Year) JUN 0 4 2	32 Aegis	strar's Signa	D. Apr	uke					

1 - For State Registrar

			1. Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of Death	
н	Physic /Medi		JESSE REESE ROSENBERGER, SR.		JUNE	E 3 2009 11:03		
many by	Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death				
			9337 Ramblebrook Rd.	Perry Hall		Baltimo		
и	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 219 • 03 • 3886 7. Age (In yrs. last birthda 4. Sex 7. Age (In yrs. last bir	Months Days Hours Min	8. Date of Birth (Month, Day,) Aug. 21	Year) 9. Birthp	place <i>(State or Foreigi</i> htry) yland	
à	Director		Usual Residence of Decedent		Aug. 21	,1322 Mar	утани	
	yland now		10a. State 10b. County 10c. City, Town or	Location		1	0d. Inside City Limits	
	a-fsh	ctor	Maryland Baltimore	Perry Hall - Baltin	nore Coun	ty	1 □ Yes 2 No	
	or 28	Dire	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Cour	ntry?	
	72 hours after death with the Maryland natural", or items 23a or 28a-f show filest Examiner must be notified at	Funeral Director	9337 Ramblebrook Rd.	21236		USA		
	item:	Ë	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married ★ Married 11 ★ Married 12 ★ Married 12 ★ Married 13 ★ Married 14 ★ Married 15 ★ Married 15 ★ Married 16 ★ Married 17 ★ Married 17 ★ Married 17 ★ Married 17 ★ Married 17 ★ Married 17 ★ Married 17 ★ Married 17 ★ Married 18 ★ Married 18 ★ Married 18 ★ Married 19	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	etc.	
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menlal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.	1	21. Signature of Funeral Service Licensee	22 Name and Address of Facility Lassann Funeral Ho	me.		-	
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			23a. Part 1. The the disease, or compile ations that caused the death. Do not show, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death	
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier La Certifying Physician: To the best of my knowledge, de					
	he Ho in 24 he Fu pletel	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occur	red at the time, dat	te and place, and due t	o the cause(s)	
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E	X		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)	0 01	27/		
-	· · · · · ·	at a	31. Date filed (Month, Day, Year) 32. Registrar's Signature	n Kd 13 all, Inc	1 1	456		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Month Yea Kamsan AM Baker May 2009 8:10 Claude 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death NIA **Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number Age (In yrs. last birthday) Days Hours 1 M 2 F 216-20-2488 81 MD Nov. 22 1927 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 Yes 2 No MD Baltimore <u>Timonium</u> 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? USA 12240 Roundwood Rd. #808 21093 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No white Specify Specify: 3 Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ General Dentist Denistry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Claude B. Ramsay Catherine G. Love 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Denise Vigliotti/daughter 1413 Turnberry Way, Bel Air, MD 21015 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 6-5-09 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial Gardens Timonium, MD 21. Signature of Funeral 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 Wichael ∕1- la• ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. 23a. Part 1. Enter the disease, shock, or heart failure. List or Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis Due to (or as a consequence of) respiratory insuth Due to (or all a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy Dav Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4X Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 □ No Ýes 2 No 1 Yes

Physician /Medical **Examiner**

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Division of Vital Records, P.O. Box 68760,

disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ Completed 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \sum Nursing Home Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) ၉ 27. Manner of Death Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) Injury 1 Natural 1 Tes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only one and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

To the I

Anne Lewi 31. Date filed (Month, Day, Year)

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32. Registrar's Signature Barke

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD

600 North Wolfe St, Baltimore, MD, 21287

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State Registra KES-000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Said Raheem Herman 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death 1aryland Ttill al If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours **X**□M 2□F Months 54 29 54 MD 218-60-7866 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10h County 1**火** Yes 2 ☐ No Baltimore MD NA 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21223 301 North Fulton Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, GiveX Year or Dates: 1 Never Married 2 ☐ Married 1 ☐Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Home Improvement 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Tisha Shavita Bennett Hamid Abdul Raheem 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 301 North Fulton Ave, Baltimore, Md 21223 Stephen Raheem-Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1√ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/5/09 Baltimore, Md Zion 22. Name and Address of Facility March F/H West 21. Signature of Funeral Service Ligensee 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) ue to (or as a consequence of): Due to (or as a consequence of): Due to (or s a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Dav 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Nonknown

Physician /Medical Examiner

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7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical

25. Was case referred to medical examiner?

1 Yes 2 1 No

27. Manner of Death

14 Natural 2 ☐ Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

Date of Injury (Month, Day, Year)

24a. Was an

autopsy performed? (es 2 No 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

26. Place of Death (Check only one)

Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 28d. Describe how injury occurred

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

> SOMACI VAZDI

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23ta) (Type Frint)

Hospital:

5 Pending investigation

6 ☐ Could not be

31. Date filed (Month, Day, 32. Registrar's Signature

2 ER/Outpatient 3 DOA

28b. Time of Injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2009 Rose Catherine Stewart une /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner onsv W0 timor Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. 1 ☐ M 2 🙀 F Months Days Hours 217-03-6452 Director July 18, 1916 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; if tem 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Experiment into the rollified at aprice. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 709 Maiden Choice Lane RGT 205 21228 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ∐Yes 2 ⊠ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ģ White Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Interviewer Telecommunication 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Quincy Adams ပ Rose Bronakowski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tim Stewart Son Stanley Drive; Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 6/5/2009 Baltimore, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licensee M01050 1630 Edmondson Avenue; Catonsville MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** eu monia one week /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): g physician and is the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, で Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) has been signed by the a e 2 should be detached to 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>გ</u> 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate ha autopsy performed 1 ☐ Yes 2 ☐ No 1 □ Yes 2 -NO funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 0 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 1 Inpatient After this 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation ours after death, neral Director; Af filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I
completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medi and manner stated. 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) Name and address of person who completed cause of death 12 (Item 23a) (Type, Print) Maiden DICE 31. Date filed (Month Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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09-04379 Mark Sautter Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ark Sautter		For State	te of Mary	land /		rtment of tificate of		and l	Mental	Hyg		Reg. No	2	0 0	9 1	790
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene Important: If item 27 is marked other than injury or other traumatic event, the Medical		24. Signature of Funeral Service		10.0	- 14.1		lame and A	ddress o	of Facility	Sin	gleto	n F	uneral Glen Bu	& C	remat:	ion 21061
Physician	1	23a. Part I. Enter the disease, or failure. List only one cause	complications the	at caused	014 the death	. Do not enter t	ne mode of	dying, s	uch as car	diac or	respiratory	arrest,	shock, or heart		Approximat Between C	e interval
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ion ttendii death. etor: A	atio	Natural 5 Pen-	ding 6-	1-09		9:30 I			es 2 X		unkno		eet and Number	or Ru	ral Route Ni	mber City
Division tal or Attendi us after death.	Certification:	3 Suicide 6 X Cou	id not be	Place of Ir <i>cify)</i> re		nome, farm, stre	et, factory,	office b	uilding, etc	D. 1	or Tov	vn, Sta	te) 1404 Marylan	Nor	crest	Dr.
y file box		4 Homicide 29a. Certifier 1 Certifying P	hysician: To the	hest of m	v knowler	dge death occ	urred at the	time, da	ate and pla	ce, and	due to the	cause(s) and manner	as stat	ed.	
To the Ho within 24 Completel	Medical	one) 2 Medical Exa	miner: On the ba	asis of exa ner stated.	mination	and/or investig	ation, in my	opinion	, death oc	curred a	t the time,	date ar	nd place, and du 29d. Date signe	e to tr	e cause(s)	(r)
	Ž	29b. Signature and title of certification	er //				290	O.C.I	e number M.E.	06	OME		June 2, 200		ritin, Day, roc	<i>u</i>)
— ,		30. Name and address of person	who completed	cause of	Marin (Ite	m 23a))									
A		Theodore M. King, Jr				Examiner	111 Pe	nn Str	reet, Ba	ltimor	e, MD 21	1201				
	ate	11.130 (1.71	2000 3	2 Registra	ar's Signa	ture	alas P									
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day Year Physician MARY ANN SHIPLEY 11:30 ам May 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Morton Hall Pasadena Anne Arundel If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, **Funeral** Months Days Min. 1 □ M 2 🖵 F Hours 219-30-2124 75 Director April 16,1934 Usual Residence of Decedent vithin 72 hours after death with the Maryland 10b. Count 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, Ihu Medical Examiner must be notified at Director MD Anne Arundel 0denton 1 ☐ Yes 2 ☑ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2504 Amber Orchard 21113 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White þ Specify 3 ₩ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Seamstress/ Designer Coat Factory 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental F Michael Galuska Esther Packech 2 permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark D. Gunther 2104 Janer Drive, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Memorial Park 6/3/2009 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully Polyniak Funeral Home PA 21. Signature of Funeral Service Licensee 3204 Mountain Road Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) burial-Due to (or as a consequence of) Box 68760, physician The law requires that the death certificate be Physician/Medical the as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy page perform this certificate oeatn 1 □ Yes 2 **So**No Sons Residence 1∏Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death

1 Natural
2 □ Accident 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation † □Yes 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Marylan EVAN J. Broadway LIPSON 401 North 363

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

ORIGINAL

32

Registrar's Signature

09-04234 India Smith

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day May 27, 2009 India Nariah Smith **Medical Examiner** 2147 hrs 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Anne Arundel Baltimore Washington Medical Center Glen Burnie 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Months Davs Hours Min. Director Country) Maryland M 2XF 3 214-73-7072 06/30/2005 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show a 1 Yes 2 X No Maryland Anne Arundel Pasadena death with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 354 San Gria Court 21122 U.S.A. Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 X Never Married 2 Married 2 X No Yes 2 X No specify: Specify: Black Pages I and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", oor other traumatic event, the Medical Examiner or Widowed Divorced f Yes, Give Year <u>გ</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 N/A N/A Dependent Dependent 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Byron N. Smith, Sr. Carrie Youngbar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carrie E. Youngbar (Mother) 354 San Gria Court Pasadena, Maryland 21122 20a, Method of Disposition

1 A Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page:
Department o
Important: I Glen Haven Mem. Pk. 06/01/09 Glen Burnie, Maryland Other Specify 21. Signature of Juneral Service Licensee 23. Name and Address of Facility McCully—Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 23a. Parl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrestaliure. List only one cause on each line. **Probable viral infection associated with** Approximate Interval **Physician** Between Onset and /Medical Death complications of congenital heart disease Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical AMENDED 23a,27, perME, g893 7/22/09 TT ned by the attending physician detached for use as the burial -X UNPENDED Division of Vital Records, P.O. Box 68760, IE FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Year Fetal death Day past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 ✓ No 9 Unknown 9 Unknown Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 ✔ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of certificate has performed? . death? ✓ Yes 2 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death

To the Funeral Director: After this certific 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Other₄ Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 Other: Certification: To 1 V Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 1 Yes 2 No the Pending Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 28, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Ana Rubio MD. 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) . Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 2 State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 1009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 24 Hrs. Yea If Unde Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral Vear) Hours Davs Maryland 1**X**□ M 2 □ F 69 216 26 7311 Director 11/11/1939 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination to the motified at 1 □Yes 2X No Director Anne Arundel Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4306 Belle Grove Road 21225 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1∏Yes 2□No IfYes, Give Year or Dates: Viet Nam 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: 2 Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Warehouseman B. Green Food's 7th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Madeline Dressel Charles Stinebaugh ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Stinebaugh / Wife Baltimore, Maryland 21225 4306 Belle Grove Road 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, Maryland Bayview Crematory 05/28/2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Parn. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Congestive Heart Failure** Immediate Cause (Final disease or condition resulting in death) **Physician** 30 + days /Medical Examiner Acute Renal Failure 7 days Sequentially list conditions, in any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). certificate be executed Bone Marrow 2 days by the attending physician and tached for use as the burial-trar Due to (or as a consequence of): 2 days /Medical Sepsis IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2√ No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy performed 1 Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ∐ Yes Marient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred

P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death Division of Vital

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1 Natural

2 Accident

3 Suicide

29a, Certifier

4 Homicide

31. Date filed (Month

within 24 hours a

To the Funeral C

completely filled

State Registrar

DHMH 17 Rev 1/2001

Medical

5 Pending investigation

6 ☐ Could not be

and manner stated. 29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

UNIVERT

Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ORIGINAL

1 ☐Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

			1 - For Amend Ite	State o	f Marylan	d/Depa 2,06/6	artment of F 04/09dhb rtificate of	lealth and Death	d Mental Hy	giene Reg. No. 2 N	0 17000	
			Decedent's Name (First, Middle)				timodio or i	<i>-</i>	2. Date of De	eath	3. Time of Death	
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and 2	S E D S	Be	17. Father's Name (First, Middle, L	•					•	, Maiden Surname)		
7	and Menta is marked aumatic ev	ပ္	Henry A. Sti 19a. Informant's Name/Relationsh			100 1407	A 1 1 (2)			O'Connor		
Na Na Na Na Na Na Na Na Na Na Na Na Na N	alth an 27 Is r r trau		Charlotte U	1 1 27	ster	1				oer, City or Town, Sta		
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Dan J	Department of Health and Men Important: If Item 27 is marked any Injury or other traumatic of	l	21. Signature of Fun ral Service L	icensee	11111	10	Name and Address			e Ave. B e of Ess		
			23a. Part1. Enter the disease, or on shock, or heart failure. List of	complications that comply one cause on e	aused the dead						Approximate Interval Between Onset and Death	
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the deat	signed by the attending I	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		pirth 2□Feta nant at time of d own		Ectopic pregnancy Other (specify)	у		Month Day Year		
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2 E	n. After this certificate ha funeral director, page	n: To	27. Manner of Death	28a. Date	of Injury	28b. Time of	28c. Injury Work			dence 6 Other (Specify)	
endin C	or: Aff	atio	1 Natural 5 Pending 2 Accident investiga	ation	th, Day, Year)	Injury		Yes 2 □ No				
al or Att	s after de	Certification:	3 Suicide 6 Could no determin	ot be ned 28e. Place buildii	of Injury - At hong, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (City or To	Street and Number o wn, State)	r Rural Route Number,	
To the Hospital or Attending Physician: The law requires that the death certif	within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (29a. Certifier (Check only one) 2 Medical E	xaminer: On the b	best of my kno- asis of examina ner stated.	wledge, death tion and/or inv	occurred at the tir	ne, date and pla pinion, death oc	ace, and due to the curred at the time,	cause(s) and manne date and place, and	er as stated. due to the cause(s)	
7 €	withir To th comp	Me	29b. Signature and title of certifier				29c. License			29d. Date signed (M		
(T	0		Janua	ulli	Well.	a MI) N	2718	8	6-1-	-09	
/			30 Name and address of person w	ho completed caus	e of death (Item	23a) (Type, F	Print)	011	• •		-09 MD 21222	
	Stat	re.	31. Date filed (Month, Day, Year)	1 / VIL	egistrar's Signal		well.	PIG	Ce De	Madall	MI) 21222	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Marcele Spuras 2009 May 29. 9:15 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 1108 Flamingo Road Baltimore <u>Baltimore</u> Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 X F 215-30-5011 Director 96 3/9/1913 Lithuania Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1108 Flamingo Road 21227 Funeral USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 Man No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify. 3. Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 } permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "n any Injury or other twan-Elementary/Secondary (0-12) College (1-4or 5+) 8 0Seamstress Tailoring 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mikolas Kuliesius Ursule Kuliesius 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jenina Spuras / Daughter 1108 Flamingo Road Baltimore, Maryland 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 6/2/09 Baltimore, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. 23a. Part 1. Enter the disease, or conshock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 50,616 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine tan, teading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for sels considered off be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760. Physician/Medical The law requires that the death certificate attending p as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) signed by the a Ö 1 ☐ Yes 2 ☐ No 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be rector, page 2 s autopsy 1 □Yes 1 ☐ Yes 2 No of Vital 2 NO To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. p 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier Medical Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7-1 MEHIS GF 32. Registral Signature

29b. Signature and title of certifie

31. Date filed (Month, Day

and manner stated

29c. License number

29d. Date signed (Month, Day, Year)

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Division of Vital Records, P.O. Box 68760,	oital or Attending Physician. The law requires that the death contificate be executed
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/Med		Mildred 4a. Facility Name (If not institution, give street and number		Sutton	a Landina of Dooth	June 1		of Dooth	3:30a M
Exam	iner	5911 Genesis Lane		Frederi	r Location of Death		4c. County	erick	
Funera	1	5. Social Security Number 6. Sex 7. Ac	ge (In yrs. last bir	thday) If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	rth T	9. Birthpl	lace (State or Foreign
Directo	r	055-16-6539 1□ M 2 [*] F Usual Residence of Decedent	88	Yrs. Months Days	Hours Min.	(Month, Da 10/27/	1920	Coun	try)
yland	١.	10a. State 10b. County	10c. City, Tow	n or Location				10	Od. Inside City Limits
e Mar	Funeral Director	Md. Frederick	Free	derick					1 ☐ Yes 2 ☐ No
vith th	Dire	10e. Street and Number		10f. Zip Code			10g. Citizen of V		try?
eath v	eral	5911 Genesis Lane 11. Marital Status 12. Was Decedent	Everin II C	2170				SA	
iter d		Armed Forces?		13. Was Decedent of H If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	Blac	e - America k, White, e	
ural", or	a b	34⊡ Widowed 4 □ Divorced If Yes, Give Year or Dates:		1 □ Yes 2 (2) No	Specify:		Specify	Whi	te
ges 1 and 2 should be filed within 72 hours after death with the Maryland ges 1 and 2 should be filed within 72 hours after death with the Martal Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, Ite Marken Evant her must be could	Completed	15. Decedent's Education (Specify only highest grade completed)	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired		ng	16b. Kind of Bu	siness/Ind	ustry
withir iene. than	d mo	Elementary/Secondary (0-12) College (1-4or to 12 th	5+)	Homemake			Own	Home	
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uld be Wenta Irked Itic ev	To B	Alfred Lent			Josep	hine S	Smith		
2 sho and is ma	i.	19a. Informant's Name/Relationship (Type. Print)	19b	. Mailing Address (Street	and Number or Rura	al Route Numb	er, City or Town,	State, Zip	Code)
1 and 2 Health tem 27 is		Robert W. Sutton		553 Jessamin					
ages int of l		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	cemeter	Disposition (Name of ry, crematory or other place	e) ;	ate	20c. Location -	•	
permit. Pages 1 and 2 Department of Heath a Important: If item 27 is any injury or other tra		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Bayvie	ew Crematory			Baltimo		
permi Depar Impor any ir		Mules)	22. Name and Addre	Schi	munek I	Funeral	Home	of BelAir
		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each li	the death. Do r	1610 West M not enter the mode of dyir	g, such as cardiac o	r respiratory a	Bel Air	, Ma.	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	500	IXPE					Onset and Death
/Medical		resulting in death)	consequence	of):					8 1000010
LAdiiiilei	١.	Sequentially list conditions, b. Due to (or on		-£\.					
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The law requires that the death certificate are has been signed by the attending physoage 2 should be detached for use as the	hysid	1 ☐ Yes 2 🗷 No 4 ☐ Pregnant a 9 ☐ Unknown	tunie or death	5 ☐ Other (specify)					
s that gned be	by P	Part II. Other significant conditions contributing to death b	ut not resulting in	the underlying cause give	en in Part I.	23e. Did t	obacco use contr	ibute to the	e cause of death?
w requires to be a signal should be a	ted t	CAD		-		1 🗆 1	Yes 2 No	3 ☐ Proba	ably 4 Unknown
law r nas be	Completed					24a. Was		Vere autop	sy findings available
20 0	5						rmed?	leath?	2 □ No
sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?		Oth	26. Place of Death	·			
Attending Physician: r death. ector: After this certific by the funeral director, p	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatie 27. Manner of Death 28a. Date of Inju		tpatient 3 DOA Other	4 28 Nursing Hor		dence 6 Other)
nding ath. r: Afte e fune	ation	1 XNatural 5 ☐ Pending (Month, Da 2 ☐ Accident investigation	<i>y, Year)</i> Ir	njury Work	? Yes 2 □ No	.ou. Describe i	low injury occurs	ou.	
r Atte er dea recto	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc.	ury - At home, far	m, street, factory, office	2	28f. Location (5	Street and Number	er or Rural	Route Number,
iital o Ins aft ral Di						City or Tov			
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier (Check only one) Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner sta	f examination and	, death occurred at the tir d/or investigation, in my o	ne, date and place, a pinion, death occurr	and due to the ed at the time,	cause(s) and ma date and place, a	inner as stand due to	ated. the cause(s)
To the within To the comp	Me	29b. Signature and title of certifier		29c. License	e number	n	29d. Date signed	(Month, E	Day, Year)
		Kein som Cl	uf	R050	603 M	٧.	6-2-2	WA	
		30. Name and address of person who completed cause of d	The state of the s	Λ τ	N	10 3.	702		
Sta	ate_	31. Date filed (Month, Day, Year) 32. Registra	ar's Signature	y Ave tred	sericis, N	0.01	106		
Regist		JUN 0 4 2009 Persena		barker					
	2001		1-14						

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

items 23a or 28a-f show ner must be notified at

traumatic event, the Medical Expression

and Mental Hygiene.

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau once.

Director

Funeral

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Completed

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altimore, Maryland 21215-0036

ettending physician and or use as the burial-transi signed by the

P.O. Box 68760.

Division of Vital Records,

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Physician/Medical Examiner Be Completed by To the Hospital or Attending Physician: The law require within 24 hours after death. To the Funestal Director. After this certificate has been si completely filled in by the funeral director, page 2 should I Certification: To

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect c. Due to (or as a consect d.				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3 ☐ Ectopi	c pregnancy (specify)		23d. Date of delivery Month Day Year
Part II. Other significant condition	contributing to death but not res		g cause given in Part I.		co use contribute to the cause of death?
(I/SD) (A)				24a. Was an autopsy performed 1 □ Yes 2	
25. Was case referred to medical examiner?			26. Place of C	eath (Check only one)	
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□	DOA Other: Walursing	Home 5 TResidence	e 6 ☐ Other (Specify)
27. Man or of Death Natural 5 Pending a Accident investiga	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how it	njury occurred
3 Suicide 6 Could no		ome, farm, street, fact	ory, office	28f. Location (Street	t and Number or Rural Route Number,

	24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No
26. Place of Dea	th (Check only one)
ther: Alursing H	ome 5 ☐ Residence 6 ☐ Other (Specify)
uryat ork? □Yes 2□No	28d. Describe how injury occurred
	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	a, and due to the cause(s) and manner as stated. Irred at the time, date and place, and due to the cause(s)

29a. Certifier
(Check onl
one)

4 Homicide

29b. Signature and little of certifier

Sertifying Physician: To the best of my knowledge, death occurred at the 2 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated

29d. Date signed (Month, Day, Year) JUNE 1, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DULANEY VALLEY ROAD TIMONIUM, MD 21093 2300 NAKHUDA,

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State

Medical

Baltimore, Maryland 21215-0036

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Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and	completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
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	-	for State Registrar		State of	iviai yi	•	rtificate of		_	g. No. \cap		17010
		Decedent's Name (First, N	iddle, La	ıst)					2. Date of Death	40	A A	3. Time of Death
Physicia /Medic		Thomas E	Ste	ewart					May 20	, ^{Day} 2009	Year	9:20 PM M
Examin		4a. Facility Name (If not instit	ution, giv	e street and num	ber)		4b. City, Town, o	r Location of Death		4c. County	of Death	
		19515 Fre	der:	ick Road	#182	2	Germant			Montgo		
Funeral Director		5. Social Security Number 214-60-1371	6. 8	Sex 1MM 2□ F	7. Age (In	yrs. last birthday) 56 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Aug 16,	Year) 1952	9. Birthp Coun Mary	lace (State or Foreign ltry) Land
pu »		Usual Residence of Decedent 10a. State 10b. Co.			100	. City, Town or Lo	ocation				1	0d. Inside City Limits
hours after death with the Maryland tural", or items 23a or 28a-f show at Examiner must be notified at	ŗ			omery	100		nantown				'	1 □Yes 2 □No
r 28a	Director	10e. Street and Number	nego	omery		Geri	10f. Zip Code		10	g. Citizen of W	hat Coun	itry?
h with	a D	19515 Freder	ick	Road #18	82			20876		USA		
deati	Funeral	11. Marital Status		12. Was Deced	dent Ever i	in U.S. 13.	Was Decedent of H	- Hspanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		e - Americ	can Indian,
or ite		1 ☐ Never Married 2 ☐		1 □Yes	2 (X) No		1 ☐ Yes 2 No		Thours, c.c.,		whi	
"natural",	d by	3 ☐ Widowed 4 X Divo		Year or Da	tes:							-
"nat	lete	15. Dece (Specify only h	dent's E ghest gra	ducation ade co <i>mpleted)</i>		16a. Dece	dent's Usual Occup kind of work done	oation during most of work d)	ing 1	6b. Kind of Bu	siness/Inc	dustry unk
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lid be fenta rked ric ev	10 B	Wesley Elmo	er St	tewart				Eleanor	Clara Jo	hnson		
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" any Injury or other traumatic event, It a Madical Expone.		19a. Informant's Name/Relati Wesley Stewa				19b. Maili 2290	ng Address <i>(Street</i> Stoneykn	and Number or Ru oll Colon	ral Route Number, ial Beacl	City or Town,	State, Zip	Code)
s 1 and 1 Hea	ŀ	20a. Method of Disposition			20	b. Place of Dispo	osition (Name of		Date 2	0c. Location -	City or To	own, State
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permit Depar Impor any In once.		21. Signature of Funeral Ser Rona Lo	ice Lice	Wade, D	Her			ess of Facility omy Board MD 2120		Baltimo	ore S	Street
		23a. Part 1. Enter the disease shock, or heart failure.	e, or com	plications that ca	used the d	death. Do not en	ter the mode of dyi	ng, such as cardiac	or respiratory arre	st,		Approximate Interval Between
Physician		Immediate Gause (Final disease or condition	List of ity	/Sala		*** - C 4 #	0 001	Lovasa	1 .	1,000	CC	Onset and Death
/Medical		resulting in death)		a. Due to to	or as a con	sequence of):	<u> </u>	HONAZO	CAN A A	20,00		UME
Examiner		Sequentially list conditions	-	b. En	4 9	Yaze	Co	00				
sit ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Į	Due to (d	or as a con	nsequence of):						
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n certi	N/M	IF FEMALE: 23b. Was decedent pregnant	.	23c. If yes, outo			_			23d. Dat	e of delive	ery
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The cate by	Con								perform 1 □Yes 2		death? I∐Yes	2 No
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Physic this cal dire	၉	1 Yes 2 No		L		2 ER/Outpatie	III 3 LI DOA		ome 5 Resider			fy)
ding I	ion	27. Manner of Death 1 Natural 5 □ Pe		28a. Date o (Month	n, Day, Yea	ar) 28b. Time o	Wor	ryat rk?]Yes 2 □ No	28d. Describe how	v injury occurr	ed	
ttenc death ctor: y the	icat	3 ☐ Suicide 6 ☐ Co	estigatio uld not b	e 200 Place	of Injury - /	At home farm st	reet, factory, office	IYes Z INO	28f. Location (Str	eet and Numh	er or Run	al Route Number
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physi completely filled in by the funeral director, page 2 should be detached for use as the to the thing the funeral director.	Medical C	29a. Certifier 1. Cert (Check only 2. Med	ifylng Pi ical Exa	hysician: To the miner: On the ba	sis of exa	knowledge, dea mination and/or i	th occurred at the to	ime, date and place opinion, death occu	, and due to the carred at the time, da	use(s) and ma	anner as s	stated. o the cause(s)
o the vithin o the	Me	29b. Signature and title of ce	rtifi <i>gl</i>		Ci Stated.		29c. Licens	se number	29	d. Date signed	d (Month,	Day, Year)
F > F 0		Jes 20	1.			OME	Do	0428	1	ney	28	2009
		30. Name and address of per	son who	completed cause	of death	(Item 23a) (Type,	,	olupi s	DICA F	me	Dr 0 9	0902
Sta		31. Date filed (Month, Day,)	-		gistrar's S	ignature			1			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Day Year **Physician** 1500 D M 2009 LILLIE VAN 05 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner nospila ST Battimore N/A If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6 Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 M 2 XF Director 219-30-4242 77 JUL. 8 1931 NORTH CAROLINA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner high be notified at 1XX es 2 □ No Director MARYLAND BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 items 23a 3714 W. COLDSPRING LANE 21215 U.S.A. Completed by Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐Yes 2 No Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than * Elementary/Secondary (0-12) College (1-4or 5+) 12th grade NURSE HEALTH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LELLIE EDWARD MILLER EVA LEE WIGGINS ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health au
Important: If item 27 is
any Injury or other trau 21044 Petrina Miller/Grandaughter 10218 Hickory Ridge Rd., Columbia, Md., 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Buriai 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 06-06-09 WOODLAWN CEMETERY WOODLAWN, MARYLAND 21. Signature of Early 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Maller 1206 W NORTH AVENUE, BALTIMORE, MARYLAND 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) STOPHY 10 LOCCUS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (briasia do that the death certificate be executed burial-tran Due to (or as a consequence of): Physician/Medical Box IF FEMALE: for use 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month 1 ☐Yes 2 ☐ No detached o 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown completely filled in by the funeral director, page 2 should Be Completed aw 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed certificate 1 □Yes 2 □ No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 hpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

σ. Vital/Récords, Hospital or Attending Physician: The 3 Division of 24 hours after death. within 2

> State Registrar

alagiri andana 31. Date filed (Month D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

andane

(Check only

29b. Signature and title of certifier

one)

32. Rajistrar's Signature park

7)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29c. License number

Avenue

29d. Date signed (Month, Day, Year)

Baltimore

2000€

1 - For State Registrar

Physic		FRANK SMITH							Month MAY		Day Year 2009	8:35a M
/Med		4a. Facility Name (If not institution		reet and numb	per)		4b. City, Town, o	r Location of D	eath		4c. County of Dea	
		3138 McELDER				In a to be dead of the dead	BALTI If Under 1 Year		Hrs. 8. Date o	Dieth	N/A	thplace (State or Foreign
Funera Directo	•	5. Social Security Number 218–44–0783	6. Sex	M 2□F	Age (in yrs.	last birthday) Yrs.	Months Days		Min. (Month	Day, Yes -194	ar) Cc	ARYLAND
and		Usual Residence of Decedent 10a. State 10b. County	,		10c. Ci	ty, Town or Lo	cation					10d. Inside City Limits
Marylan f show	ŏ											1∭ Yes 2 ☐ No
r 28a	Director	MD • N 10e. Street and Number	/A			BALTIM	10f. Zip Code			10g.	Citizen of What Co	ountry?
h with	alD	3138 McELDER	RY SI	Γ.			2120	5			USA	
ems (Funeral	11. Marital Status	12	2. Was Decede	as?	I.S. 13. \	Was Decedent of H	Hispanic Origin an, Mexican, F	? (Specify Yes o Puerto Rican, etc.	r No-	14. Race - Ame Black, Whit	
s afte	by Fu	1 ☐ Never Married 2 ☑ Mar 3 ☐ Widowed 4 ☐ Divorced		1 ☐Yes 2 If Yes, Give Year or Date	ΜNο		1 □ Yes 2 □ No	Specify:			Specify: B]	
hour	ed t	15. Deceder			8S:	16a. Dece	dent's Usual Occup	pation		16b	. Kind of Business	/Industry
e. San "ng	plet	(Specify only higher Elementary/Secondary (0-12)	st grade o	completed) College (1-4	or 5+)	(Give	kind of work done DO NOT use retire	during most of	working			
filled within 72 hours after death with the Maryland filled within 72 hours after death with the Maryland wither than "natural", or items 23a or 28a-f show ent, the Medical Experience must be to filled at	Completed	-12-		-0-		WE	LDER	1			J & L V	ANCE INC
be file Ital Hy d oth	Be	17. Father's Name (First, Middle,						11	Name (First, Mid		den Surname)	
ould Men	၉	WILLIAM SMIT				401 14 77	4.11 (01		ROTHY HA		7 T	Zi- Code)
d 2 st Ith an 17 Is r traur		19a. Informant's Name/Relations RUBY SMITH(W)		e. Print)							ity or Town, State, MARYLAND	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla popartment of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, the Prodict Exp. injury must be notified at		20a. Method of Disposition			20b.		sition (Name of natory or other pla		Date		. Location - City or	
Page: Tent o		t Burial 2 Cremation 4 Donation 5 Other		moval from St	ate		NATIONAL		5-2009	LA	UREL, MAI	RYLAND
mit. partn porta y Inju	ġ	21. Signature of Funeral Service	Licensee	MONATH							ERAL HOMI	
8 8 8 8 6 8 6	ā	Heralt	<u>こ) (</u>	J. GA	B-							YLAND 21217
		23a. Part 1. Enter the disease, o shock, or heart failure. Lis	r complica t only one	ations that cau cause on eac	ised the dea ch line.	th. Do not ent	er the mode of dyi	ng, such as ca	rdiac or respirato	ry arrest,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease by condition resulting in death)	a.		LON		ANCER	2				
/Medica Examine				Due to (or	as a consec	quence of):						
	je je	Sequentially list conditions, if any, leading to immediate	b.	Due to (or	as a consec	quence of):						
cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	S c.									
be executed sician and burial-transit		resulting in death) Last		Due to (or	as a consec	quence of):						
cate b	dica		d.									
death certificate be executed eattending physician and d for use as the burial-transit	sician/Medical	IF FEMALE:	230	c. If yes, outco	me of pregn	ancv				_	23d. Date of de	alivery
death atter	iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No		1 ☐ Live bir 4 ☐ Pregna	th 2□Fet ntattime of	al death 3 [☐ Ectopic pregnand ☐ Other <i>(specify)</i> _			_	Month	Day Year
	Physi	9 Unknown		9 Unknov	vn							
The law requires that the law requires that the safe has been signed by the bage 2 should be detached.	by P	Part II. Other significant conditi	ions contr	ributing to dea	th but not res	sulting in the u	nderlying cause giv	ven in Part I.				to the cause of death?
w requires to be a signal should be a										I □ Yes	2 No 3 F	Probably 4 Unknown
law l has b e 2 sh	Completed									Was an autopsy	prior to	utopsy findings available completion of cause of
	ပ်								1 🗆 Y	es 2 X		
Attending Physician: r death. ector: After this certific by the funeral director,	Be	25. Was case referred to medica examiner?	_	spital:] FD/O-1#-	ot all par Oth		Death (Check o		0.000	
Phy er this	n: To	1 Yes 2 No 27. Manner of Death		28a. Date of	Injury	ER/Outpatier 28b. Time o	IL 3 L DOA	4 LI Nuis			e 6 ☐ Other (Sp njury occurred	acity)
tending leath. tor: After the funer	atio	1 Anatural 5 Pending 2 Accident invest	ng igation	(Month	Day, Year)	Injury		rk?]Yes 2 □ No				
To the Hosefial or Atterwishin 24 hours after dea To the Funeral Director completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deterr		28e. Place o building	f Injury - At h g, etc. <i>(Spec</i>	nome, farm, str ify)	eet, factory, office			on (Stree r Town, S		Rural Route Number,
ours a		29a. Certifier 1 Certifyi	na Physi	cian: To the h	est of my kn	owledge deat	h occurred at the t	ime, date and	place, and due to	the caus	se(s) and manner	as stated.
the Hospital hin 24 hours the Funeral I	Medical	(Check only 2 Medical one)	l Examine	er: On the bas and manne	sis of examin	ation and/or in	vestigation, in my	opinion, death	occurred at the t	ime, date	and place, and du	e to the cause(s)
To the Within To the Comp	M	29b. Signature and title of certific	er .				29c. Licens				Date signed (Mor	
		1861	100/2				DO	06716	53		06/02/	2009
		30. Name and address of person					Print) 1191, BAL	TIMPE	MN :	122		
	tate			32 Rec	gistrar's Sign	ature			110 -		1	
Regis		31. Date filed (Month, Day, Year JUN 9 4	2019	Centr	ر به	b. for	Med					. *
HMH 17 Rev 1	/2001					7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Physician 3^{Day} 200^{Yea} 7:30 PM Ross Thornton June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Parkville Genesis Eldercare Perring Parkway If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Y Sept 29, Birthplace (State or Foreign
Country) 5. Social Security Number Age (In yrs. last birthday, **Funeral** 1940 Maryland 1**X**) M 2□ F 215-40-4670 68 Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f sh notified 1 ☐ Yes 2 No Director Baltimore Maryland Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or be r 21234 ms 23a (1801 Wentworth Drive USA Funeral 14. Race - American Indian Black, White, etc. "natural", or items a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status I □ Yes 2 X No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Completed by 3 ☑ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Trucking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mable Foebus Horace R. Thornton မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bel Air, Maryland 21015 1409 Moonshadow Ross Thornton, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any injury or c 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 06/04/09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Thomas Gregor ²² Name and Address of Facility Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that consect the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each hiline. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Facron disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No been signed by the should be detached 9□Unknown 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Winknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe certificate 2 No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760, the Hospital or Attending within 24 hours after death

To the Funeral Director;
completely filled in by the

> State Registrar

DHMH 17 Rev 1/2001

Medical

31. Date filed (Month, Day, Year)

SHONIS A

29b. Signature and title of certifier

29a. Certifier

(Check only one)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mD

1 😔 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

31464

29d. Date signed (Month, Day, Year)

13 ALTIMUSILE MY 21261

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** Month Year 2300 M William Milton Taylor May 27, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Salisbury Rebabilitation & Nursing Ctr S Do Social Security Number 8. Date of Birth (Month, Day, Dec 13, 9. Birthplace (State or Foreign **Funeral** Months 1 X M 2 □ F Days Hours Min. Maryland 1940 215-38-2340 Director 68 Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Infortant: if item 27 is marked other than "natural" or items 23a or 28a-f show any lojury or other traumatic event, the Pedical Examination and to a rediffed at once. Director 1 □Yes 2 No Willards Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21874 USA 36344 Old Ocean City Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No white If Yes, Give Year or Dates: Specify Completed by 3 ☐ Widowed 4 🔯 Divorced Baltimore, Maryland 21215-00 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) technician electronics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Henry Annie Dale ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Brown/sister 35907 E. Line Road Willards, MD 21874 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee State Anatomy Board 655 W. Baltimore Street rector Baltimore, MD 21201 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Seas /Medical Due to (or as a consequence of) Examiner Par. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Month Year 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 es 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 □ No 1 □Yes 2 → No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 1€ No Other: 4 Hursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manne Leath 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending investigation 1 41 atural To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records,

State

Medical

(Check only one)

29b. Signature and title of certifie

lilliam H. Robins

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MID.

Registrar DHMH 17 Rev 1/2001 VIC

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

			Please	Type or Prir							-			.		
			For State	State of Ma	arylan					d Me	ntal Hy	giene	9	0	170	
			Registrar 1. Decedent's Name (First, Middle, Las	**)		Ce	rtificat	e or l	Death	1 2	Date of De	Reg. No	200	y	3. Time of De	anth.
	Physicia	an	Norma Lil		tura						Month une 2	Da)09 Ye	ar	12:10	
	/Medic Examin		4a. Facility Name (If not institution, give		Lula		4b. City,	Town, or	Location of De		une 2	- -	. County of D	eath	12.10	A
	Examin		4903 Carroll Cour	rt			В	aldw	v i n				Balti	.mor	e	
	Funeral		Social Security Number 6. Security Number	ex 7. Age		last birthday, Yrs.	If Under Months	1 Year Days		in. 8.	Date of Bi (Month, D	rth ay, Year	9.	Count	ace (State or F ry)	
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	vith th	Director	10e. Street and Number				10f. Zip					10g. Ci	itizen of What	Count	ry?	
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0	fter d	Fun	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ N		J. 13.			ispanic Origin? an, Mexican, Pu	erto Rio	an, etc.)		Black, W			
0000	ral",o	l by	3 ☐ Widowed 4 ☐ Divorced	if Yes, Give TYear or Dates:	*		1 □Yes	2 XI No	Specify:				Specify:	Wh i	te	
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VIGIT)	2 shoi and I is ma auma	•	19a. informant's Name/Relationship (7	Type. Print)		19b. Mail	ing Address	(Street	and Number or	Rural F	Route Numl	per, City	or Town, Sta	e, Zip	Code)	
-	and 2 fealth a im 27 is her trai		John Ventura/Hush	oand	T 001 B				Court,					210		
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· F	Physician		Immediate Gause (Final disease or condition resulting in death)	. /-	NZ	hein	neu	5	Disca	se					Onset and De	ath
. ,	/Medical Examiner		resulting in death)	Due to (or as	a consequ											
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5	/sicia s cert directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🏋 No	Hospital:	ent 2 🗆	ER/Outpatie	ent 3 🗆 DC	Oth	er:	,			6 Mi∩ther /	Cannih	Daught Reside	ers
5	og Phy ter thi	n:T	27. Manner of Death	28a. Date of Inju	iry	28b. Time o		28c. Injur Worl					ury occurred	opecity	Reside	nce
SICI	tendir eath. or: At	catic	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				M	1 🗆	Yes 2 □ No							
Ž	or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ury - At ho c. <i>(Specif</i> i	ome, farm, si	treet, factory	, office		281	Location City or To			r Rura	Route Number	er,
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1X Certifying Ph	ysician: To the best	of my kno	wledge, dea	th occurred	at the ti	me, date and p	lace, an	d due to th	e cause	(s) and mann	er as s	ated.	
	ne Ho n 24 h ne Fui pletely	Medical	(Check only 2☐ Medicai Examone)	niner: On the basis o and manner sta	f examina	tion and/or i	nvestigation	n, in my o	opinion, death o	occurred	at the time	, date a	nd place, and	due to	the cause(s)	
	Vithi Vithi Con	ž	29b. Signature and title of certifier				290	c. Licens	e number			29d. D	ate signed (N	lonth, i	Day, Year)	
			MUS	Jus				132	543				June 3	, 20	009	
1	0 V		30. Name and address of person who	•		, , , ,		٠.	and to	/.10 <i>/</i>	т		MIL)	2120	١/،	
	Sta	te	Mark R. Strombe: 31. Date filed (Month, Day, Year) JUN 0 4 2009	32. Registr	ar's Signa	ture Jana	Les S		surre	4100	, TOM	SON	, MD ,	<u>. 1 Z (</u>) †	
	Registr		JUN 0 4 2009	cener	Ju.	19										

			For S	tate of Marylan		artment of H			iene	2.0	17010
			State Registrar		Cer	tificate of I	Death		eg. No. U	J 9	1/9/8
	Physicia /Medic	al	1. Decedent's Name (First, Middle, Last)	ISONWE!	15			2. Date of Dea Month	02	89	3. Time of Death 2040 M
4	Examin		4a. Facility Name (If not institution, give stree	et and number)			r Location of Death		4c. County		1
			613 St. Mulberry Co	7. Age (In yrs.	last birthday)	Anna If Under 1 Year	apolis If Under 24 Hrs.	8. Date of Birth		e Arui	NGE L e (State or Foreign
	Funeral Director		216-28-7318		5 Yrs.	Months Days	Hours Min.	May 6	Year)	Mary.	land
	P.		Usual Residence of Decedent 10a. State 10b. County	100 0	y, Town or Lo	antina				10d	Inside City Limits
	shov	5	,	100. 010		nium				100.	1 ☐ Yes 2 No
	the N	Director	Maryland Baltimore 10e. Street and Number		TIHO	10f. Zip Code			I0g. Citizen of W	Vhat Country	?
	3a or	Ö	200 Belmont Forest (Court. Unit	#407	21093	3		USA	1	
	ems 2	ner	11 Marital Status 12.	Was Decedent Ever in U. Armed Forces?		Was Decedent of H	lispanic Origin? (Span, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race Blac	- American k, White, etc	
Maryland 21215-0036	72 hours after death with the Maryland neturel', or Items 23a or 28a-f show digal Erer if art must be notified at	by Funerai	1 ☐ Never Married 2 ☐ Married	1 □Yes 2 X No If Yes, Give Year or Dates:	1	1□Yes 2XINo	Specify:			White	
5-0	72 na na	Completed	15. Decedent's Education (Specify only highest grade co	on <i>mpleted)</i>	(Give	dent's Usual Occup kind of work done	during most of wor	king	16b. Kind of Bu	siness/Indus	stry
121		duc	Elementary/Secondary (0-12)	College (1-4or 5+)	Teach	DO NOT use retired	1)		Flement	arv Fo	ducation
d 2	filed Hygi other		17. Father's Name (First, Middle, Last)	<u>+</u>	reacti	CL	18. Mother's Nan	ne (First, Middle,			adcation
<u>la</u> n	Q to 0	To Be	Charles A. Wilson, S	Sr.			Marian	Jones			1
lary	d 2 should h and Men 7 is marke traumatic		19a. Informant's Name/Relationship (Type,	•	T	ng Address (Street					
6, 6	s 1 and f Health item 27 other tr		Nancy Wells Graham, 20a. Method of Disposition		_	t. Mulber		Anna ol	LIS, Mar 20c. Location -		
nor	0 0		1 ☐ Burial 2 【 Cremation 3 ☐ Rem. '4 ☐ Donation 5 ☐ Other (Specify)			sition (Name of natory or other place matory In			Baltimo	-	
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee			Name and Addre remation 99 Freder					
	20200		23a. Part1. Enter the disease, or complicati	ons that caused the deat						A	pproximate
	Prysician		shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death) a.	ayse on each line.	231	11 1	due		,		nterval Between Onset and Death
	/Medical Examiner		Sequentially list conditions b.	Due to (or as a conseq				H7	/	1	ylen
	ted nsit	Examine	day, reading to inmodulate cause. Enter Underlying Cause (Disease or injury that initiated events c	peanus a sa ro) of euC	mentse ory						
,09/	ficate be executed physician and is the burial-transit		that initiated events c resulting in death) Last	Due to (or as a conseq	uence of):						-
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O. Box	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	ıl death 3[⊒Ectopic pregnancy □ Other (specify) _	4		23d. Dat Mo	te of delivery nth Da	ay Year
Δ.	quires that n signed b uld be deta	by	Part II. Other significant conditions contrib	uting to death but not res	ulting in the u	nderlying cause giv	ven in Part I.				cause of death?
Vital Records,		Completed						24a. Was autop perfor 1 \(\text{Yes} \)	rmed2	Were autops prior to comp death? 1 \(\sum \text{Yes} \) 2	y findings available bletion of cause of
/ita	Physician: The rthis certificate har al director, page	Be	25. Was case referred to medical examiner?	nital.		0#		ath (Check only o	ne)	I	authter's
of	는 판 =	. To	1 Yes 2 No Hos	onal. 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatier 28b. Time o	and the same of th	4 Nursing F	lome 5 Resid	lence 6 XOth		Residence
on	of the second	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wo	rk? Yes 2 □ No		, , , , , , , , , , , , , , , , , , , ,		
Division	I or Attendi after death. Director: A I in by the fu	Certification:	6 Could got be	28e. Place of Injury - At h building, etc. (Special		reet, factory, office		28f. Location (S City or Tox	Street and Numb vn, State)	er or Rural F	Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical C		an: To the best of my kno On the basis of examina and manner stated.							
	To th within To th	Me	29b. Signature and title of certifier	Am		29c. Licens	se number 2	1438	29d Date signe	d (Month, Da	ay, Year) 3, 2009
			30 Name and address to person who comp	HENTA U	NY	111 112	FENSE	HIGHL	Ay AN	NAPUL	USM DENGUI
	Sta	ate	31. Date filèd (Month, Day, Year)	32. Registrar's Agna	aturgark	1			1 4		
	Regist	rar	JUN 0 4 2009 /	know p.	7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] [] 9 Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 29 2009 11:20p May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince Georges Larkin Chase Nursing Facility Bowie If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 12 M 2□ F Sept 28 1937 NC 244-52-0199 71 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow the Mudical Examiner must be notified at 1 ☐ Yes 2X No Director Prince Georges Upper Marlboro 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ō USA 20772 2809 Matapeake Dr. or Iteme 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1955**–** 1961 1 ☐ Yes 2 XNo Specify: Be Completed by 3 Widowed 4 Divorced Black "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygies
Important: If Item 27 is marked other th
eny injury or other treumstic event, this
once. Treasurer Bakers Union 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dewey Beaty Helen Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Wright-Wife 2809 Matapeake Dr. Upper Marlboro, MD. 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 6-9-2009 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, MD. 21. Signature of Funeral Service Licensee Marshall s Funeral Home of Maryland 4308 Suitland Rd. Suitland, Md. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) _{a.}Dementia **Physician** /Medical Due to (or as a consequence of): Examiner Cerebrovascular Accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed physicien and s the burial-transit _c Hypertension Due to (or as a consequence of): Completed by Physician/Medical attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 3 Ectopic pregnancy ò 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signe should be Chronic Kidney Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 🗗 No 1 Yes 20 No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending s after de. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide within 24 hours a

To the Funerel C

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D45217 6/1/2009

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address

Adebwa**lé** Ajayi

JUN 0 4 2009

31. Date filed (Month, Day, Year)

Maryland 21215-0036

Baltimore,

Box 68760,

P.O.

Records.

Division of Vital

Berwyn Hgts., MD 20740

npleted cause of death (Item 23a) (Type, Print)

6201 Greenbelt Rd.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 20a-c, & 22, per Fh g892 6/5/09 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month 9.20 PM **Physician** WILSON DORIS MAY 2009 24 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Future Care Irvington Raltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Max 26, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Mary Land 1 □ M 2 🛱 F 59 Director 214-52-8757 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. and the than "netteral", or items 23a or 28a-f show shit: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, he Medical Examinar matter notified at any or other traumatic event, he Medical Examinar matter notified at 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 1√2 Yes 2 □ No Funeral Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21229 USA 3330 Wilkens Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 TXNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2X No Specify. Specify: black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) food industry dietician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willie B. Wheeler Clifton Stevens ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21207 Betty Goodman/cousin 3005 Fairview Rd Gwynn Oak, MD Department of Health Important: If item 27 any Injury or other to once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in 3 € a.1 State Chesapeake Crematory June 2,82009 Beltswille, MD Green Pastures Dr. State Anatomy Board 655 W. Baltimore Street 21. Signature of Europa Survice Licensee Waster Waster Wargetor Baltimore, MD 21201 21286 Stephen D. Lohrman ens Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE MYOCARDIAL INFARCTION **Physician** HREE disease or condition resulting in death) /Medical WEEKS . Due to (or as a consequence of): **Examiner** ORONARY ARTEKY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 Other (specify) o 9 I Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by STAGE CARDIOMYOPATHY. CHRONIC RENAL FAILURE GERIPHERAL VASCULABA Was an autopsy performed?

1 DISEASE. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown has been s 24b. Were autopsy findings available prior to completion of cause of death? page TYPE IT DIABETES MELLITUS. 1 ☐ Yes 2 ☐ No Division of Vital : After this certification of the thick of t 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 🕱 Nursing Home 5 🗌 Residence 6 🗆 Other (Specify) 1 ∐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0018362 09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

K. Dang

JUN 0 4 2009

31. Date filed (Month, Day, Year)

3455, Wiltens Ave Suite 40. Balto.

			State of Maryland / Department of Health and M 1 - State Amend Item 29d per dr., g892,06/04/09dhb Certificate of Death	lental Hygier	ne	17001
_		_	1. Decedent's Name (First, Middle, Last)	2. Date of Death	2009	3. Time of Death
	Physicia	an		Month E	Day Year	N ACO M
	/Medic		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	05 2	c. County of Death	21.10
	Examin	er	18 11:			
a describ	Francis		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	9. Birthp	ace (State or Foreign
	Funeral Director		216-68-5113 1M 2 F 5 Yrs. Months Days Hours Min.	(Month, Day, Yea	Coun	try)
			Usual Residence of Decedent	.,		<u> </u>
	yland		10a. State 10b. County 10c. City, Town or Location		10	Dd. Inside City Limits
	Marfsl	ctor	MD Kaltimore			1 X Yes 2 □ No
	h the	ire	10e. Street and Number 10f. Zip Code	10g. (Citizen of What Coun	try?
	h wit	al	409 tennsylvania Avenu Apt 18 21201		USA	
	dea	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	ecify Yes or No- Bican, etc.)	14. Race - Americ Black, White, e	
9	or ite		1 ☐ Never Married 2 Married 1 ☐ Yes 2 TNo If Yes, Give 1 ☐ Yes 2 TNo Specify:	, 110411, 0101,	Specify:	1.
5-0036	ours	d by	3 □ Widowed 4 □ Divorced Year or Dates:		blu	ck
,	72 h 'natu	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of worki		Kind of Business/Inc	lustry
2	/ithin han h	d l	Elementary/Secondary (0-12) College (1-4or 5+)	. 72	Smallel :	144.1
7	led v Hygie her t	ပိ	12th Floor Echniel Middle Leet 12 Middle Leet 13 Method Name	(First, Middle, Maid	an Surnama)	1,1016
ŭ	vuld be filed Mental Hygi arked other atic event, I	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name 10. 10. 10. 10. 10. 10. 10. 10. 10. 10.	72 D. 1	en sumame)	
<u>=</u>	2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Evaminer must be notified at	은	Charles White Isuncy	(D. 100)	inson	0-1-1
Maryland	es 1 and 2 should b of Health and Ment fitem 27 is marked r other traumatic e		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rura 19b. Mailing Address (Street and Num	al Houte Number, Cit	y or 10wn, state, 21p	A / 1 /
	1 and Health sm 27 ther t		20a. Method of Disposition 20b. Place of Disposition (Name of	Date 20c.	Location - City or To	Md ZJZ0/
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altimore,	it. Partment rtant		4 Donation 5 Other (Specify)	109	uito. II	neral Service
Ba	permit. Pages Department of Important: If it any injury or c		21. Signature of Funeral Service Lice is 22. Name and Address of Facility Va	Man Cit	Treene In	neral Service
	_		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of	or respiratory arrest	0., 1010.012	Approximate
		S 1	shock, or heart failure. List only one cause on each line. Immediate Cause (Final	o. roop.iaio. y airooi,		Interval Between Onset and Death
	Physician /Medical		disease or condition a			
	Examiner		Due to (or as a onsequence of):			
	40	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	uted d ansit	mi	Sequentially list conditions, if any, leading to immediate Cause. Enter Undership Cause (Disease or injury that initiated events			
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8760	ficate be executed physician and s the burial-transit	dical	d			
9	tifica ng ph as th	ledi				
Box	w requires that the death certifice been signed by the attending should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the part 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of delive	·
	deal ne att	icis	in the past 12 months? 1 Yes 2 No 9 Unknown		Month	Day Year
<u>Ч</u>	at the by the	hys	9 Unknown			
	ss the	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	ne cause of death?
ğ	en si			1 Dives	2 No 3 Prob	pably 4 ☐ Unknown
Records,	law re las be 2 sho	ompleted		24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
	The page	E O		performed	? death?	
Vital	iclan: The law certificate has rector, page 2 s	Be C	25. Was case referred to medical 26. Place of Death	h (Check only one)	V-1	
			examiner? 1 Yes 2 No Other: 4 Nursing Ho	me 5 Residence	e 6 ☐Other (Specif	y)
0	ng Pł fter tł neral	ü	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Work? 28c. Injury at Work?	28d. Describe how in	njury occurred	
<u>Ö</u>	Attending r death. ector: After by the fune	atic	2 Accident investigation M 1 Yes 2 No			
Division of	r Att	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, St	t and Number or Rura tate)	I Route Number,
	ital or rrs af					
)	Hosp 24 hor Fune felly fi	edical	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, one of my knowledge, death occurred at the time, date and place, one of my knowledge, death occurred at the time, date and place, one of my knowledge, death occurred at the time, date and place, one of my knowledge, death occurred at the time, date and place, one of my knowledge, death occurred at the time, date and place, one of my knowledge, death occurred at the time, date and place, one of my knowledge, death occurred at the time, date and place, one of my knowledge, death occurred at the time, date and place, one of my knowledge, death occurred at the time, date and place, one of my knowledge, death occurred at the time, date and place, one of my knowledge, death occurred at the time, date and place, one of my knowledge, death occurred at the time, date and place, one of my knowledge, death occurred at the time, date and place, one of my knowledge, death occurred at the time, date and place, one of my knowledge, death occurred at the time, date and place, one of my knowledge, death occurred at the time, date and place, one of my knowledge, death occurred at the time, date and place, date and place, date and place, date and place, date and date			
/	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Med	29b. Signature and title of certifier 29c. License number	29d.	Date signed (Month,	Day, Year)
	F 3 F 8		19525603	Tana	ne 4, 2009	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	777		
		1	I an Pilha 22 South Crooks (L R-1)	timero	MN	21261
	Sta	te	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Refistrar's Signature 33. Aparel 34. Aparel		3	
	Registr	ar	JUN 0 4 2009 Senew B. Jak			

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** ,2009 Oneda N. Winston May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Joseph Richey Hospice Baltimore if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 11,1911 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 97 Virginia 216 22 4841 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State "natural", or items 23a or 28a-f show adical Examiner must be notified at 1 ☐Yes 2 ☐ No n/a Director MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 1400 E. Madison Apt.1007 21205 USA Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 □Yes 2 □ No Specify. Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical marked other than Elementary/Secondary (0-12) College (1-4or 5+) 2 yrs Nurse Nursing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Henry Nollie Alice Bradly မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health a Joseph Nollie (nephew) 4001 Clarks Lane Balto,Md. Important: If item 2 any injury or other once. 20c. Location - City or Town, State Date 5 , 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Maryland National Mem. Pk. Laurel, 4 Donation 5 □ Other (Specify) Schature of Funeral Service Licens 22. Name and Address of Facility Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto, Md. Approximate Interval Between Onset and Death MON 10.5 23a. Part 1. Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Ö 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed 2 🗆 No 1 ☐ Yes 2 Z 1 ☐ Yes Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DDA Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSDICE 1□Yes 2□No Medical Certification: To 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 1 Natural
2 Accident 5 Pending investigation 1 ☐Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mafiner stated. 29a. Certifier 29b. Signature and title of certifier

State Registrar

6

31. Date filed (Month, Day,

who completed gause of death (Item 23a) (Type Print)

32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

32 Registrar's Signature

09-04312 Yolanda Young Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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ູ Physician edical Examine	-	. Decedent's Name (F	irst, Middle			37					1 1	nonth lay 30, 2	Day	Year	1017	hrs
edicai Examini		a. Facility Name (if no	t institution	Yolar give street and	number)	<u> Yoı</u>	ang 4	c. City, Tow	n, or Lo	cation of E	Death		4	c. County of De	ath	
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Funeral	5	. Social Security Num	ber	3. Sex	7. Age	(In yrs. last	t birthday)	If Under 1	Year Days	If Under 2 Hours	24Hrs. 8 Min.			VDD/YYYY) 9.	reign	i
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5-0036 led within 72 Hygiene. other than the Medical	ompleted	llth g			N/A				1 1:	8.Mother's	Name (F	irst, Middle	e, Maide	en Surname)		
Hygi	ပ၊	17. Father's Name (Fi	rst, Middle, Rui						- 1	Chr				ung		
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Media	e Be	19a. Informant's Name					19b. Mailin	g Address	(Street	and Numb	er or Rur	al Route N	lumber,	City or Town,	State, Zip Co	de)
MD 21215-0036 at 2 should be filed within 72 hours after death with the Maryland alth and Mental Hygiene. m 27 is marked other than "natural", or items 23a or 28a-f she aumatic event, the Medical Examiner must be notified at once	-	Tyrone					509	N. I	1126	rne	Ave	nue	Ba.	Lto, M	D 212	05
and 2 and 2 and 2 traul		20a. Method of Dispo	sition			1	Place of Dispos rematory or ot		e of cerr	netery,	-	Date	20	ic. Location - Ci	nty or Town, s	nate
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587 artifica ding p	sician/Me	23b. Was decedent p past 12 months?	regnant in		ive birth	at time of de		etal death Other (Spec	3	Ectopi	c pregnar	icy		Mona	Duy	
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of \oldsymbol{V} g Phy g Phy her thereal	۳	27. Manner of Deati	_	28a	Date of I	njury y,Year)	28b. Time o	of Injury		ury at Wor	_	28d. Desc	cribe ho	w injury occurre	ea	
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ivisior or Attend after death Director:	≝	3 Suicide	6 Co	ould not be 286		f Injury - At I	home, farm, st	reet, factory	y, office	building, 6	etc.	or To	wn, Sta	ite)	or or reare.	,
Di Hospital of 24 hours a Funeral I	Certification:	4 Homicide			ecify)							due to the		(s) and manner	as stated.	
Hos Fun fely		29a. Certifier (Check only one)	Certifying	Physician: To t	he best of basis of e	f my knowle examination	dge, death oc and/or investi	curred at th gation, in m	e time, o iy opinic	date and p on, death d	ccurred a	at the time,	date a	nd place, and d	lue to the cau	use(s)
To the J within 2 To the J	Medical	29b. Signature and		anu ilia	nne <u>r stat</u>	ed				se numbe				29d. Date sign	ed (Month, L	Day, Year)
	≥	1 112		0 11	11	l			0.0	.M.E.				May 31, 20	009	
		30. Name and a or	mill per	on who complete	d cause	of death (Ite	em 23a)		_							
)	İ	Margarita K			t Medic	al Exami	iner 111	Penn St	treet, l	Baltimo	re, MD	21201				
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State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		,	Certificate		n and Men th		. No. 2 A A (17025
	Dhusisi		Decedent's Name (First, Middle, Last)					Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Wilson Coleman		Sr.				lay 19	2009 4c. County of Deal	8:56 A M
	Examin	er	4a. Facility Name (If not institution, give	street and number)			own, or L <i>o</i> cation stead	on of Death		Carroll	
_	Funeral		3477 Shiloh Road 5. Social Security Number 6. Se		e (In yrs. last b	oirthday) If Under 1		der 24 Hrs. 8. [Date of Birth Month, Day,	9. Birt	hplace (State or Foreign
	Director		219-30-0997	X M 2□F	74_	Yrs.		Ju	ne 26,	1934 Mar	yland
	ow at		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Location				· · · · · · · · · · · · · · · · · · ·	10d. Inside City Limits
	a-f sh	ctor	Maryland Carroll		Hamps	tead					1 ☐ Yes 2 XNo
	with th	Funeral Director	10e. Street and Number 3477 Shiloh Road			10f. Zip (g. Citizen of What Co nited Stat	-
	ns 23	eral	11. Marital Status	12. Was Decedent B	Ever in U.S.			Origin? (Specify ican, Puerto Rica		14. Race - Ame	erican Indian,
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X\ If Yes, Give Year or Dates:	10	1 ☐ Yes 2			in, etc.)	Black, Whit	white
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Mar	nd 2 sh Ith and 27 Is m rraum		19a. Informant's Name/Relationship (7) Burdell L. Adkins			96. Mailing Address (8477 Shilo				Maryland 2	
e,	of Hea		20a. Method of Disposition	Domesial from State	20b. Place ceme	of Disposition (Nam tery, crematory or ot	e of her place)	May 23		Oc. Location - City or	
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Dall	permit Depart Import any in		21. Signature of Funeral Service Licen	n I	401072	934 Sou		Street	Hamp		ryland 21074
			23a. Part1. Enter the disease, or compshock, or heart failure. List only o	olications that caused one cause on each lin	I the death. Do	o not enter the mode	of dying, such	n as carmac or re	spiratory arre	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	a consequenç	HC N	max	001	Cuu I	Jr. cq	2 MOS.
	Examiner		Commentally list conditions	Fu	1000		umes	rico			IWK.
ŭ.	pe jis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequenc	Se of):					
,	ficate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as	a consequenc						
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or Vital Records, P.O. Box	 Hospital or Attending Physician: The law requires that the death certificate hours after death. Funeral Director: After this certificate has been signed by the attending select filled in by the funeral director, page 2 should be detached for use as 	Certification: To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome 1	2 Fetal death ut not resulting ent 2 Fe/ iny y Year) 28t ury - At home, ic. (Specify)	ath 3 Ectopic prospective of the underlying carried or the underlying	26. P A Other: 4 Work? 1 Yes at the time, dat	Place of Death (C	1 Ye 24a. Was ar autops; perform 1 Yes 2 Pheck only one 5 Reside Location (Str. City or Town	Month acco use contribute s 20 No 3 F 24b. Were a prior to death? 1 Ve a) nce 6 Other (Sp w injury occurred reet and Number or it, State)	Day Year to the cause of death? Probably 4 □ Unknown autopsy findings available or completion of cause of security) Bural Route Number, as stated.
or Vital Records, P.O. Box	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome 1	2 Fetal death ut not resulting ent 2 Fe/ iny y Year) 28t ury - At home, ic. (Specify)	ath 3 Sectopic professor of the underlying case of the underlying ca	use given in Pour 26. P A Other: 4 Bc. Injury at Work? 1 Yes 20, office at the time, dat in my opinion.	Place of Death (C Nursing Home 28d 2 No 28f. te and place, and, death occurred	1 Ye 24a. Was ar autops perform 1 Yes 2 theck only one 5 Reside Describe ho Location (Str. City or Town	Month acco use contribute s 20 No 3 F 24b. Were a prior to death? 1 Ve a) nce 6 Other (Sp w injury occurred reet and Number or it, State)	Day Year to the cause of death? Probably 4 □ Unknown autopsy findings available a completion of cause of as 2 □ No ecify) Bural Route Number, as stated. ue to the cause(s)
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or Vital Records, P.O. Box	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical Certification: To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome 1	2 Fetal death ut not resulting ent 2 Fe/viny y Year) 28t examination ated.	Outpatient 3 DO b. Time of Injury M farm, street, factory dge, death occurred and/or investigation (29c) (a) (Type, Print)	use given in Pour 26. P A Other: 4 Bc. Injury at Work? 1 Yes 20, office at the time, dat in my opinion.	Place of Death (C Nursing Home 28d 2 No 28f. te and place, and, death occurred	1 Ye 24a. Was ar autops perform 1 Yes 2 theck only one 5 Reside Describe ho Location (Str. City or Town	Month acco use contribute s 27 No 3 F n 24b. Were a prior to death? 1 Ve a) nce 6 Other (Sp w injury occurred reet and Number or in, State) ause(s) and manner ate and place, and di	Day Year to the cause of death? Probably 4 □ Unknown autopsy findings available a completion of cause of as 2 □ No ecify) Bural Route Number, as stated. ue to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2009 **Physician** 22, 9:02 a. M Henry Clayton BYWATERS, SR. May /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Washington Hagerstown 11 Park Avenue If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday 5. Social Security Number 6 Sex Date of Birth (Month, Day, **Funeral** Days Hours 213-24-8919 1 TX M 2 □ F 81 5, June 1927 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show at 1 ☐ Yes 2 No Washington Maryland Hagerstown 27 Is marked other than "natural", or items 23a or 28a-f st traumatic event, the Medical Examiner must be notified Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21740 U.S.A. 11 Park Avenue Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 X Yes 2 No 1944filed within 72 hours after 1 Never Married 2 Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. 1945 ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) machinist Truck Company d 2 should be filed w th and Mental Hygier 7 Is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Newton Bywaters Lydia Isabelle Hager 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 Is,
any injury or other trans 11 Park Avenue, Hagerstown, Maryland Grace E. Bywaters - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐Removal from State May 27 Boonsboro Cemetery 4 Donation 5 Dother (Specify) Boonsboro, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MINNICH FUNERAL HOME lob 415 E. Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each type. Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (a nsequence of **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-trar and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccourse contribute to the cause of death? 2 2 □ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 ☐ Yes 2 ☐ No 1□ Yes 2 | N Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 10 1 Inpatient 2 ER/Outpatient 3 DOA 1 TYes Certification: To filled in by the funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manne Death 28c. Injury at Work? After (Month, Day Year) Injury 5 ☐ Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident Within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Che the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 auxel of death (Item 23a) (Type, Print) d address of person who

Registrar
DHMH 17 Rev 1/2001

State

ell

MAY 27 2009

31. Date filed (Month, Day, Year)

ORIGINAL

111

Registrar's Signature

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21742

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Wyatt Arthur Bell 2009 MA-22 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Rockville Shady Grove Adventist Hospital 8. Date of Birth (Month, Day, Year) Country)
April 24,2009 Maryland Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **X** M 2□F Days Hours 213-85-2299 28 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b, County 1 ☐ Yes 🎾 No Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21740 903 Harwood Rd. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 🎢 No Specify. 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Heather Palmer Dwane Bell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 903 Harwood Rd. Hagerstown, MD 21740 Heather Palmer-mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 Removal from State 5-26-2009 Hagerstown, Maryland 4 Donation 5 Other (Specify) Rose Hill Cemetery 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service License 1331 Eastern Blvd. North Hagerstown, MD 21742 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or com shock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Resolution fa muscular Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes 2 □ No 2 No 25. Was case referred to medical examiner? 26. Place of Death | Check onl one 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3☐ DOA 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28d, Describe how injury occurred (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be

The law requires that the death certificate be executed the burial-tran physician and Division or Vital Records, P.O. Box 68760, þ signed t page 2 should certificate has Physician: funeral director. After this Hospital or Attending To the Hospins. ...

within 24 hours after death.

To the Funeral Director: A'

Examiner Physician/Medical

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifited at

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

3 ☐ Suicide

þ Be Completed Certification: To

Medical

29a. Certifier

29b. Signature and title of certifier

determined 4 Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2009

1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

Neonetologia 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James Rost, MD Shady Grove Adventist Hospital Rockville, MD 20850

State Registrar 31. Date filed (Month, Day, Year) MAY 27 32 Registrar's Signature

		1 - State of I	Maryland / Depa <i>Cel</i>	artment of He rtificate of D			iene g. No. 200	9 17929
Physi	ician	1. Decedent's Name (First, Middle, Last) John Victor Bixler				2. Date of Death Month	Day Y	3. Time of Death
/Med	dical	4a. Facility Name (If not institution, give street and number	er)	4b. City, Town, or L		May 20,	2009 4c. County of	2:50 a M
		Long View Nursing Home		Manches			Carr	
Funera Directo		215-40-0311 ¹ X ^{M 2□ F}	Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Jun 4,	1925	Birthplace (State or Foreign Country) Maryland
/land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits
e Mary Ba-f sh	ctor	Maryland Carroll		Wes	tminster			1 XYes 2 □ No
with th	Funeral Director	360 Logan Drive		10f. Zip Code	21157	10	0g. Citizen of Wh	at Country? USA
r death	nera	10 Mas Decede	nt Ever in U.S. 13.1	Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Spe , Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.
USO Irs afte	by Fi	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 □ If Yes, Give Year or Date			Specify:			white
5-UUSO 72 hours aff hatural", or	eted	15. Decedent's Education (Specify only highest grade completed)	16a, Dece	dent's Usual Occupati kind of work done du	ion ring most of worki	na I	l 16b. Kind of Busi	ness/Industry
within liene.	Completed	Elementary/Secondary (0-12) College (1-4c	life	Farmer	Ü		Agricu.	lture
Dattilliore, Interfiging 21213-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it. Medical Evancians to nother traumatic event, it. Medical Evancians	To Be C	17. Father's Name (First, Middle, Last) Herbert Bixler		1	8. Mother's Name	(First, Middle, Me Kroh	faiden Surname)	
2 shou and M ls mar ls mar aumat	-	19a. Informant's Name/Relationship (Type. Print) dau	_	ng Address (Street an				
t and t and Health Health		Cynthia Christine Bixler 20a. Method of Disposition		Logan Drive			MD 2115	
Pages nent of ant: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	te SOULII-	sition (Name of natory or other place) Crematory	}	/2009	Winfie	
permit. Pages Department of Important: If it any Injury or or	once	21. Signature of Funeral Service Licenses		2. Name and Address 91 Willis	of Facility My Street,	ers-Durk Westmins	oraw Fu	neral Home 21157
		23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	sed the death. Do not ent	er the mode of dying,	such as cardiac o	or respiratory arre	est,	Approximate Interval Between
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Examine	_		as a consequence of):					
ted sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	as a consequence of):					-
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ficate be executed physician and sthe burial-transit	dical	d						
certifi anding I use as		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome					23d. Date	of delivery
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Sy P	by Phys	Part II. Other significant conditions contributing to death	but not resulting in the u	derlying cause given	in Part I.	23e. Did tob	acco use contrib	ute to the cause of death?
requir been s should	eted	COM DELEVEN	110 2121	C		1 □ Ye		Probably 4 Unknown
ding Physician; The law h. h. After this certificate has funeral director, page 2.8	Completed		· · · · · · · · · · · · · · · · · · ·			24a. Was ar autops perforn	y pried? dea	re autopsy findings available or to completion of cause of ath?
Iclan; Sertifica Sector, p	Be C	25. Was case referred to medical examiner?			26. Place of Death		7.	Yes 2/4No
J Physics of this control of the serial directions of the serial direct	1: To	27. Manner of Death 28a. Date of I		28c. Injury a	4 Nursing Hor		nce 6 Other	
ending eath. or: Afte	atio	2 Accident investigation	Day, Year) Injury	Work?	es 2□No		,,,,	
al or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of building,	Injury - At home, farm, streetc. (Specify)	eet, factory, office		28f. Location (Sti City or Town		or Rural Route Number,
To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical (29a. Certifier (Check only one) CertifyIng Physician: To the be 2 Medical Examiner: On the basis and manner	s of examination and/or in	h occurred at the time vestigation, in my opin	e, date and place, nion, death occurr	and due to the ca	ause(s) and man ate and place, an	ner as stated. d due to the cause(s)
To th within To th	Me	29b. Signature and title of certifier	^	29c. License r	1705		/= 0	Month, Day, Year)
hour		30. Name and address of person who completed cause o	f death (Item 23a) (Type	Print)	1705		5-2	0,-0,
3		30. Name and address of person who completed cause of the person who cause of the person who cause of	Hanover_	BINO,	Ham	pstead	1 wh	1 210/4
S Regis	tate strar	MAY 21 2009	un B. Aga	ake				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-03912 Matthew Barcase State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. Registrar 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 16, 2009 2029 hrs **Medical Examiner** Matthew Benjamin Barcase 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Berlin Worcester Atlantic General Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Director Country) MD 220-37-8676 1 X M 2 16 Yrs 2/16/1993 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State Yes 2 X No or items 23a or 28a-f show must be notified at once. Berlin Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygeine.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho MD Worcester Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 21811 USA 10 Fantail Court Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. White, etc. Armed Forces? 1 X Never Married 2 Married Yes 2 X No Divorced Yes. Give Year Yes 2 X No specify: Specify: White Widowed Examiner ş 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Medical n/a 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Cindy Barcase Richard Forde Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Cindy Wittmyer / mother Fantail Court, Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date crematory or other place) or other Burial 2 X Cremation 3 Removal from State 5/22/2009 Frankford, DE Cape Henlopen Crem. Other Specify: Donation 5 22. Name and Address of Facility Burbage Funeral Home Sign ture of Funera Service Licensee Berlin, MD 21811 108 William St.. Approximate Interval plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear 23a. Part I. Enter the disease, or co Physician Between Onset and failure. List only one cause on each line. /Medical Death a. Head Injuries Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical UNPENDED **AMENDED** ed by the attending physician detached for use as the burial Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth 3 Ectopic pregnancy Month Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed Records, certificate has been a ector, page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? . death? page Yes 2 1 🗸 Yes No 26.Place of Death (Check only one) After this certifi funeral director, Hospital or Attending Physician: 25. Was case referred to medica Division of Vital æ examiner? Hospital: 1 Other Inpatient 2 V ER/Outpatient 3 Nursing Home 5 ٩ 1 Yes No 28a. Date of Injury (Month, Day Year May 16, 2009 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Pedestrian struck by auto within 24 hours after death.

To the Funeral Director: A completely filled in by the fun 2003 hrs 1 Natural 1 Yes 2 V No Pending 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) Rte. 50 west of Rte. 50 Bridge, Ocean City, MD determined (Specify) Major Road / Highway Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated **Nedical** 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. May 17, 2009

BA 4

31. Date filed (Month, Day, Year)

NAY 2 0 2009

Registrar's Signature

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201

State Registrar

09-03899 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Barbara Beach 2009 1793 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle,Last) Physician/ Month Day May 16, 2009 0906 hrs Medical Examiner BARBARA ANNETTE HAGGINS BEACH c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Wicomico Salisbury Peninsula Reginal Medical Center 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 8. Date of Birth/MM/DD/YYYY 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours Min Director 11/06/60 226-08-6626 M 2 48 V۸ Country) Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location ıny 10a. State 10b. County Yes 2 X No 28a-f show Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once. **MELFA** ACCOMACK Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23410 USA 27150 FISHER CR. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S Race - American Indian, Black. Never Married 2 X Married Armed Forces? White etc. Yes If item 27 is marked other than "natural", or BLACK Yes 2 X No specify: Specify: Widowed Divorced Yes. Give Yea 4 <u>ج</u> 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10 UNEMPLOYED NONE 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MILTON CHANDLER BETTY HAGGINS other traumatic event, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BETTY H. GRAY, MOTHER 624 SENIOR WAY SALISBURY. MD 21801 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date crematory or other place) 1 X Burial 2 Cremation 3 Removal from State tant: GASKINS AME CEMETERY 05/24/09 SAVAGEVILLE. Donation 5 Other Specify Signature of Fune COOPER & HUMBLES FUNERAL CO. ACCOMAC. disease, accomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart one cause on pach line. Approximate Interval **Physician** 23a Part I. Enter the Between Onset and failure. List only /Medical Death a Hypertensive Cardiovascular Disease Immediate Cause (Final disease kaminei or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Division of Vital Records, P.O. Box 68760, and or Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED the attending physician ed for use as the burial 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 V Unknown q Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş Yes 2 ✔ No 3 Probably 4 Unknown Completed certificate has been sector, page 2 should 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes 2 ✔ Yes No 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical funeral director, Be Other 4 Hospital: Residence 6 Other Inpatient 2 Y ER/Outpatient 3 DOA Nursing Home 5 After this 1 Yes 28a. Date of Injury (Month, Day, Yeer) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 V Natural neral Director: A Yes 2 No Pendina 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) Funeral determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the

2A1

State

Registrar

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

and manner stated

32

Assistant Medical Examiner

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

2009

29b. Signature and title of certifie

Margarita Korell MD.

31. Date filed (Month

29d. Date signed (Month, Day, Year)

May 17, 2009

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State of Maryland / Department of Health and Mental Hygien	9 (1 (1	ŧ
State of Maryland / Department of Health and Mental Hygien	5	5.1	-)	
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	Physici	an	Decedent's Name (First, Middle, Last)				Mo	ite of Death onth	Day Year	3. Time of Death	
t.	/Medic Examin		Mary E. Clawson 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of		lay	4c. County of Dea	1	
	Examin	eı	9040 Bush Creek Circle		Fre	deri	ck		Fred	erick	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	//	If Under 1 Year Months Days	If Under 2 Hours	Min. (M	te of Birth onth, Day, Ye	9. Bir C 1922 I	thplace (State or Foreign ountry)	
	pu ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of	or Loc	ation					10d. Inside City Limits	
	deeth with the Maryland ms 23s or 28s-f show	ō			ederick					1 Yes 2 No	
	the N	Director	10e, Street and Number		10f. Zip Code			10g.	. Citizen of What C	ountry?	
	3a or	ā	9040 Bush Creek Circle		21	704			United S	tates	
20	be filed within 72 hours after deeth with the Marylan lal Hygliene. d other than "natural", or flame 23a or 28a-1 ahow avent, if a Markinal Examiliar must be notified at	by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No		'as Decedent of His Yes, specify Cubar ☐ Yes 2 ☑ No	spanic Orig n, Mexican Specify:	gin? (Specify Y , Puerto Rican,	es or No- etc.)	14. Race - American Indian, Black, White, etc. Specify: White		
Ş	tural'	q pa	3 ₩ Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. D)ecede	ent's Usual Occupa	tion		16	b. Kind of Business	/Industry	
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Baltimore,	- I = =		Libural 2 Ki Cremation 3 Linemoval from State		ition (Name of atory or other place Cremator		Date 5/20/20		c. Location - City o Frederic	r Town, State	
Balti	permit. Pages Department of I Important: If Iti any injury or o		21. Signature of Funeral Service Licensee	22.	Name and Addres	s of Facility	y Stauf	fer Fu	neral Ho derick, l	ne	
68760,	Physicien and physicien and physicien and physicien and the pnifer. It is a physicien to the physicien and physici	dical Examiner	23a Pan1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) d.): n:	r the mode of dying	g, such as	cardiac or resp	iratory arrest		Approximate Interval Between Onset and Death MonHhs	
O. Box t	The law requires thet the death certificate sie has been signed by the attending phy bage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown		Ectopic pregnancy Other (specify)				23d. Date of do Month	elivery Day Year	
׆	w requires thet t been signed by should be detat	र्व	Part II. Other significant conditions contributing to death but not resulting in the	the und	derlying cause give	en in Part I.	. 2			to the cause of death? Probably 4 Unknown	
Vital Records,		Completed						4a. Was an autopsy performe	prior to death?	autopsy findings available completion of cause of	
<u>=</u>	ician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	_	To:		of Death (Che	ick only one)			
	Physic this c	6	1			4 🗆 140		/	ce 6 Other (Sp	ecify)	
5	ding P. h. After funera	tlon	1 Natural 5 Pending (Month, Day Year) Inju	jury	28c. Injury Work	res 2 □		Jeschibe now	injury occurred		
Division of	or Attan	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	m, stre			28f. L	ocation (Stre	et and Number or I State)	Rural Route Number,	
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical Co	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, and manner stated. Certifying Physician: To the best of my knowledge, and manner stated.								
	ro tha	Me	29b. Signature and title of certifier		29c. License	number		290	d. Date signed (Mo	nth, Day, Year)	
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	8		30. Name and addless of person who completed cause of death (term 23a) (Tr	Гуре, Р	Print)		-		ing "		
			Myla Carpenter MD 711	M	laider	Ch	Dolor	5	Cathon	1M ollive	
	Sta Registi		31. Date (Month, Day, Year) 32/Registrar's Signature	ba	Ke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 5 **Physician** 2009 Janice Ahalt Coblentz 14 5 Р /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4525 Deer Spring Road Middletown Frederick If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth
Month, Day Year)
11/9/1926 9. Birthplace (State or Foreign Country) MD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months 220-30-9355 1 M 2 X F 82 Director Usual Residence of Decedent 10d. Inside City Limits 10b County 10c. City, Town or Location 10a. State show "natural", or Items 23a or 28a-f shov edical Examiner must be notified at MD Frederick Middletown 1 ☐ Yes 2√ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4525 Deer Spring Road 21769 USA Funeral Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iten any Injury or other traumatic event, the Medical Examines 1 Yes 2 XNo
If Yes, Give
Year or Dates: XX Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify 2 Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nurse hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be W. Kieffer Coblentz Martha Ahalt 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Paul (Coblentz (Brother) 4435 Deer Spring Rd., Middletown, MD21769 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 □Removal from State Reformed cemetery 5/19/2009Middletown, MD tion 5. Other of Full Enal Serv 4. □D/ona Specify) 22. Name and Address of Facility
Donald B. Thompson Funeral Home Side ture POB 18, Middletown, MD 21769 Part1. Enter the disease, or cor pli shock, r heart failure. List only o Approximate Interval Between Onset and Death ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e cause on each line. Imm state Cause (Final disease condition resulting in death) Due to fir as a consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed and Due to (or as a consequence of): burial-t Division or Vital Records, P.O. Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months2 Month Day Year 5 Other (specify) I Yes 2 HNO 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? has page 2 this certificate Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Hospital: 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA P To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral. 27. Manner of eath 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Natural (Month, Day Year) М 1 □ Yes 2 □ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 🖟 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title oleted cause of death (Item 23a) (Type, Print)

State

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Registrar

Date filed (Month, Day, Year) 19

32. Registrar's Signature

09-03832 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Kenneth Close State of Maryland / Department of Health and Mental Hygiene 1- For State
Registrar
1. Decedent's Name (First, Middle,Last) Certificate of Death Reg. No. 2. Date of Death Physician/ Medical Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed

Exami	ner	Kenneth A	Allen	C1o	se, Jr.							May 13,	2009	100	-	1405 hrs	5
		4a. Facility Name (if				er)			y, Town, or	Location of	f Death			. County o	of Death		
		Howard Cour			·			1	lumbia	.				loward	J 0 50 0		
ineral rector		5. Social Security Nu 213-02-09	00/	6. Sex	7. A		ast birthday)	_	nths Days		Min.	8. Date of B			Cou	place (State ontry) yland	or Foreign
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Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Married	-	mied				f Yes, sp	ecify Cuban	, Mexican,		cify Yes or N ican, etc.)	10-	White	e, etc.	an Indian, Bla	ack,
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al Hy ced of	Be C	Kenneth Al			e, Sr.						•	Buffi			,		
Ment mark	0	19a. Informant's Nam				-	19b. Mai	ling Addr				ral Route N			n, State,	Zip Code)	
h and 27 is Imati		Kimberly I	Buffin	gto	n / Moth	ner	54 I	King	St.,	Kear	neys	zille,	WV	2543	0		
Healt item		20a. Method of Dispo				20b.	Place of Disp	osition (Name of cer	metery,	М	Date	20c.	Location	- City or	Town, State	
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sician		23a. Part I Enter the	disease, or o	complic	cations that cause	ed the death	. Do not ente	er the mo	de of dying,	such as ca	ardiac or	espiratory a	rrest, sh	ock, or he	art	Approximat Between C	te Interval
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by th	P	Part II. Other signifi	icant conditie	ons (contributing to de	ath but not r	resulting in th	ne underl	ying cause (given in Pa	ırt I.	23e. Dio	tobacc	o use cont	ribute to	the cause of	death?
igned be det	d by											1 Y	es 2	✓ No 3	Prob	ably 4l	Jnknown
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er this	2	1 ✓ Yes 2 27. Manner of Death			28a. Date of I		28b. Time	-		ry at Work		28d. Describ					
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached for	Certification:	1 Natural	5 Pendi	ìna	FOUND: Da	y,Year)	FOUND:			Yes 2						om laddei	r
ector by th	icat	2 🗸 Accident	Inves	tigatio:	28e Place of		1333 hrs					28f Location	(Street	and Numb	per or Ru	ral Route Nur	mber, City
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t hour		4 Homicide 29a. Certifier	Cartifuina Ph	veicia	n: To the best of				t the time d	ate and nla						ed	
within 24 hours after death. To the Funeral Director: completely filled in by the f	Medical			niner:	On the basis of e	xamination a											
To COI	Mec	29b. Signature and t	title of certifier		and manner state	ed.			29c. Licens	se number		—	290	I. Date sign	ned (Mo	nth, Day, Year	r)
1		1// 1	1/-	1	(117/)				O.C.	M.E.			Ma	ay 14, 2	009		
		30. Name and addre	es of person	Who a	ompleted cause of	of death /Itor	n 23a)										
2		Laron Locke	·		ant Medical E			nn Str	eet, Baltii	more, M	D 2120)1					
S	tate		h, Day, Year)		32 Regis	trar's Signat											
Regis		128 (1)	Y 192	2009	acres	بر راب	2. po	notes									
7 Rev 1/2	001		OCME		1	•	ORIGII	NAL									

3. Time of Death

		State		/ Depa		lealth and M	lental Hyg						
Physicia /Medic	al .	Registrar 1. Decedent's Name (First, Middle, Last) BUSTER CLARK	gan Pilang				2. Date of Dea Month		59 10 A				
Examine Funeral Director		4a. Facility Name (If not institution, give street and number Baltimore Rehab. & Ext. Ca: 5. Social Security Number 6. Sex 7. A 1 M M 2 F			4b. City, Town, or Baltimor If Under 1 Year Months Days	Ce If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 23, 1937 9. Birthplace (State or Foreign Country) N. Carolina						
	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Carroll	10c. City, T	own or Loc stead				10d. Inside City Limits 1▼ Yes 2□No					
filled within 72 hours after death with the Maryland Hygiene. Hygiene. Then "natural", or items 23a or 28a-f show ant, the Medical Exarciant roughts rediffed at	rai	10e. Street and Number 3810 Normandy Drive 11. Marital Status 12. Was Decedent Armed Forces			10f. Zip Code 21074 Vas Decedent of H	ispanic Orlgin? (Spo an, Mexican, Puerto	ecify Yes or No-	United Sta	ntes				
72 hours after "natural", or ite	þ	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ If Yes, Give Yes Give Yes, Give Yes Give	196	5 16a. Deced	☐Yes 2X No	Specify:		Specify: W	hite				
e filed within 7 al Hygiene. other than "r vent, in Med	Be Completed	Elementary/Secondary (0-12) College (1-4or 1 17. Father's Name (First, Middle, Last)	5+)	life. E	actor	18. Mother's Name	(First, Middle,	rovement					
nd 2 should be uith and Ments 27 is marked r traumatic e	To	Earl Clark 19a. Informant's Name/Relationship (Type. Print) Shirley Clark - wife	l			Maude Ca and Number or Rura Drive 3B	al Route Numbe	or, City or Town, State	e, Zip Code) Maryland 21074				
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once.		20a. Method of Disposition 1 Disposition 1 Disposition 1 Disposition 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee		rans	sition (Name of natory or other place Forest Cemetery . Name and Addres	20	ine Fun	eral Home	lls, Maryland				
Physician /Medical Examiner		M01072 934 South Main Street Hampstead, Maryland 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition resulting in death) Due to (or as a consequence of):											
be icia	lical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	s a consequen										
	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	23d. Date of Month	delivery Day Year									
w requires that the dispension of the should be detached	þ	Part II. Other significant conditions contributing to death	but not resultin	ng in the ur	nderlying cause giv	en in Part I.	23e. Did to	res 2 □ No 3 □	e to the cause of death?] Probably 4 Unknown				
sician: The faw r certificate has b rector, page 2 sh	Be Completed	25. Was case referred to medical examiner?				26. Place of Deat	1 □ Yes	rmed? death	e autopsy findings available to completion of cause of h? Yes 2 □ No				
ding Physic h. After this ce funeral dire	မှ	1 Yes 2 No Hospital: 1 Inpa 27 Manger of Death 1 Natural 5 Pending 28a. Date of In (Month, D	iurv 28	R/Outpatier 8b. Time of Injury	28c. înjur Wor			dence 6 Other (S	Specify)				
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, p.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of I building.	etc. (Specify)		eet, factory, office		City or Tov	vn, State)	r Rural Route Number,				
To the Hosp vithin 24 hou To the Fune completely fil	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best and manner: 29b. Signature and title of certifier	of examinatio	n andler in	restination in my	aninian dooth accus	wad at the time	data and place and	due to the cause(s)				
MATTA		30. Name and address of person who completed cause of	death (Item 2	3a) (Type,	Print)	3767	2	MAY 19	214 11				
Sta Registr		31. Date filed (Month, Day, Year) MAY 2 1 2009	rar's Signatur	A	barre	se number 23767 DLOCH S	XVIV X	yva.,e	ZIZI				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM 8 17 Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 8:25p M James Wilev Cooke May 18, 2009 /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Dove House Westminster If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth 1/20/1924 9. Birthplace (State or Foreign (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 M 2 □ F 85 Director 237-34-7791 N. C Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location a or 28a-f show be notified at 10b. County 10a State **Baltimore** 1 ☐ Yes 2 ☐ No MD -Carroll-Hampstead Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4313 Church Road 21074 USA "natural", or items 23a Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Affiled Polices: 1 ☑ Yes 2 ☐ No If Yes, Give WW II Year or Dates: WW II 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify white Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Bethlehem Elementary/Secondary (0-12) College (1-4or 5+) Shipyards carpenter supervisor 12 17. Father's Name (First, Middle, LCOOK 18. Mother's Name (First, Middle, Maiden Surname) Be William Riley Cooke Laura Jane (Cook) Cooke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Phyllis Willardsen, daughter 3818 Ruth Drive, Salt Lake City, Utah 84124 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 5/22/2009 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bakersville, Cooke Family Cemet. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Eline Funeral Home M00741 934 S. Main St., Hampstead, MD. 21074 lande Semmer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 5/17/01-5/15/1 Cardiac end **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HF Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consequence of Examiner law requires that the death certificate be executed acute ren and burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: nse 23c. if yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year detached for in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the 9 Unknown 9 ☐ Unknown signed by the 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 2 No 3 Probably 4 Donknown 1 □ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 No death? 1 ☐ Yes 2☐ No certificate 1□ Yes Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Dove House 2 No 2 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Hospital or Attending Ph 24 hours after death. Funeral Director: After th funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: To the Hosping.
Within 24 hours after deatr.
To the Funeral Director: Aft 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier WIL O MD SHIVA ame and address of person who completed cause of death (Item 23a) (Type, Print) 555 South Cartie Street Westmisson, 40 21157 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar Geneva

Amended Item 10b per F.D. 05/21/2009 Carroll County, wj1

		-	For State Registrar	State	of Mary		epartme Certifica		lealth and N Death		jiene _{eg. No.} 20	09	17937	
	Physicia	an	1. Decedent's Name (First, Mid Esther	dle, Last)	Ch	ertock				2. Date of Deal Month May	17, 200	Year	3. Time of Death 4:58 A. M	
-	/Medic	al	4a. Facility Name (If not institut	ion, give street and		er tock	4b. City	, Town, or	Location of Death		4c. County	of Death		
			Montgomery G 5. Social Security Number	eneral Ho		yrs. last birth		Olney		8. Date of Birth	Mont	9. Birth	place (State or Foreign	
	Funeral Director		096-09-2616	1 □ M 2 🛣 1		98 Yr	Months	Days	Hours Min.	8. Date of Birth (Month, Day Jan. 17	, Year) 911	Pen	nsylvania	
DCS	/land low at		Usual Residence of Decedent 10a. State 10b. Coun	ty	100	c. City, Town o	r Location						10d. Inside City Limits	
Ale	e Man 8a-f sh ptiffed	Director	-	gomery	S	ilver					I 0g. Citizen of W	/h at Cour	1 XYes 2 No	
0	3a or 2	Dir.	10e. Street and Number 15320 Pine Orc	hard Driv	re, # 2	K		ip Code 20906	5	'	U. S		тш у :	
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or items 23a or 23a-f show any Injury or other traumatic event, if a Modical Examiner must be notified at ance.	d by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Mi 3 ☑ Widowed 4 ☐ Divorce	Armed 1 ☐ Ye If Yes,	Decedent Ever I Forces? es 24 No Give or Dates:	in U.S.	13. Was Dece If Yes, sp 1 ☐ Yes		lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	Blac Specify	k, White, W	hite	
1215-(within 72 h ene. than "natu	Completed	15. Deceder (Specify only high Secondary (0-12) 12 Years	ent's Education nest grade complete Colleg	ed) le (1-4or 5+)		ecedent's Us Give kind of w ife. DO NOT Homema	ork done d use retired	eation during most of work d)	king	16b. Kind of Bu	siness/In		
land 2	ild be filed i fental Hygi ked other ic event, the	To Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pearl Schulman 19. Mailing Address (Street and Number of Bural Script Number City of Town, State 2											
/ary	2 shour and N is mai		19a. Informant's Name/Relatio	nship (Type. Print)		- 1								
Baltimore, Maryland 21215-0036	Pages 1 and ment of Health ant: If Item 27 ury or other t		19a. Informant's Name/Relationship (Type. Print) Barbarta A. Ziony - Daughter 10212 Brookmont Drive, Richmond, Virginia 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Company, State,											
Balt	permit. Departi Imports any Inj		21. Signature of Funeral Service	. State	lemyer		1091 E	lockv		e, Rockv	ille, M	nc. aryl	and 20852 Approximate Interval Between	
8760,	Cate be executed hysician and physician and the burial-transit the bur	dical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Hemorrhagic Stroke Due to (or as a consequence of): Hypertension Due to (or as a consequence of): c											
.O. Box 6	The law requires that the death certific ate has been signed by the attending pipage 2 should be detached for use as I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1 □ L 4 □ P	outcome of p ive birth 2 Pregnant at tim Inknown	Fetal death	3 Ectopic 5 Other (ey .			te of deli	very Day Year	
rds, P.	n requires that the d been signed by the should be detached	ρ	Part II. Other significant cond	itions contributing	to death but no	ot resulting in t	he underlying	cause giv	ven in Part I.	23e. Did to			the cause of death? obably 4 Unknown	
al Reco	ding Physician: The law re h. After this certificate has be funeral director, page 2 sho	Completed									rmed? 2A No	prior to c	topsy findings available ompletion of cause of	
f Vit	Physician: this certific ral director, I	o Be	25. Was case referred to medi examiner? 1 ☐ Yes 2 No		Inpatient	2 🗆 ER/Outp	oatient 3 🗆 I	OOA Oth	or:	ith <i>(Check only o</i> Iome 5 ☐ Resid		ner (Spec	cify)	
Division of Vital Records,	il or Attending Pt after death. I Director: After th d in by the funeral	Certification: To	3 ☐ Suicide 6 ☐ Cou	ding (/ stigation	Date of Injury Month, Day, Ye lace of Injury - uilding, etc. (S		ury M		ryat k?]Yes 2∐No	28d. Describe h	Street and Numb		ral Route Number,	
۵	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:		V	ying Physicien: To					ime, date and place			anner as	stated.	
	To the Hospital of within 24 hours at To the Funeral Completely filled in	Medical	(Check only 2 ☐ Medic one)	al Exeminer: On t	he basis of ex- manner stated	amination and	or investigati	on, in my	opinion, death occu	urred at the time,	date and place,	and due	to the cause(s)	
	To the To the comple	Σ	29b. Signature and title of cert	m ainl	1		2		se number 4996		29d. Date signe May 18			
			30. Name and address or pers Bichhuong M	·					e, Olney	, Maryla				
	Sta Registr		31. Date filed (Month, Day, Ye.	ar) 3	2. Pegistrar's	Signature								

DHMH 17 Rev 1/2001

09-04222 Mary Collier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ary Comer		For State Certificate of Death	Reg. N	o. 200	Time of Death
Physiciar	1	. Decedent's Name (First, Middle,Last)	Date of Death Month Day Nay 27, 2009	y Year	1205 hrs
ledical Examin		Mary Louise Collier A Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	
	4	19201 Misty Meadow Terrace Germantown		Montgomery	ulas (Otato or
Funeral Director	5	S. Social Security Number 217-82-0295 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Months Days Hours Min.		M/DD/YYYY) 9. Birth Foreign .8, 1962 Cou	ntry) Maryland
any		Jsual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
* .		Maryland Montgomery Germantown			1 Yes 2 No
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 19201 Misty Meadow Terrace 20874	"	Citizen of What Count JSA	try?
72 hours after death with the Maryland n "natural", or items 23a or 28a-f shu raf Examiner must be notified at once	<u>ē</u> -	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XXNo 13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Ric	fy Yes or No- an, etc.)	14. Race - Americ White, etc.	an Indian, Black, hite
after d	<u>8</u>	3 Widowed 4 Divorced If Yes, Give Year or Dates:	done 16	b, Kind of Business/Ir	
hours "natur		Elementary/Secondary (0-12) College (1-4 or 5+))		
036 thin 72 ne.	Completed	4 Administrative Assistan		Secretar	ial
21215-0036 Uld be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner	Be Co	Charles hiphads dellies, is	Kathleer	rriedel	
	<u>-</u>	19a. Informant's Name/Relationship (Type, Print) Richard K. Collier/Brother 19b. Mailing Address (Street and Number or Rural P.O. Box 17, Basye, Vicence and P.O. Box 17, Basye, Vicence and P.O. Box 17, Ba	A 22810		
nore, MD 21; gges 1 and 2 should be no of Health and Men tt: If item 27 is mar	t	201. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State crematory or other place) Contact of Heavy on Competitive Contact of Heavy on Contact of Heavy on Contact of Heavy on Contact of Heavy on Contact of Heavy on Contact of Heavy on Contact of Heavy on Contact of Heavy on Contact of Heavy on Contact of Heavy on Contact of Heavy on Contact of Heavy on Contact of Heavy on Contact of Heavy on Contact of Heavy on Contact of Heavy on Contact of Heavy on Contact of Heavy on Contact of Heavy on	une 2,	0c. Location - City or	
Pag ment fant	L	4 Donation 5 Other Specify:	2009		ring.Maryla
Balt permit Depart Impor		500 University Blvd	·, W.,	Home Inc. Silver Spr	ing, MD 209
Physician	7	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or refailure. List only one cause on each line.		, shock, or heart	Approximate Interval Between Onset and
(aminer		Immediate Cause (Final disease a Quetiapine and diltiazem intoxication			Death
	-1	or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):			
	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
Λ	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
760, cate be executed physician and he burial - transit		d	9 TT		
60, ate be ex hysician le burial	Medical	AUNPENDED		23d. Date of deliver	у
Aecords, P.O. Box 68760, The law requires that the death certificate be cate has been signed by the attending physicipage 2 should be detached for use as the buring.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnance	су	Month	Day Year
Division of Vital Records, P.O. Box 6876 rat or Attending Physician: The law requires that the death certifica its after death. al Director: After this certificate has been signed by the attending pt led in by the funeral director, page 2 should be detached for use as the	Physician/	1 Yes 2 No 9 V Unknown g Unknown			
D. Be t the de by the ached f		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to	
, P.(res tha signed be def	d by				utopsy findings available
rds v requi s been should	Completed		24a. Was an autopsy perform	prior to	completion of cause of
Pecc The lav	mo		1 ✓ Yes 2		es 2 No
al R	Be C	25. Was case referred to medical examiner? Hospital: 4 Inspired: 2 FR/Outpatient 3 DOA Other,4 Nursing		esidence 6 🗸 Otho	ar: Scane
Vit Physicial al dire	To E			w injury occurred Sonally ove	
n of		1 Natural 5 Dentiles 1 Yes 2 A No 1	intentio	onálly ove otion medi	rdbsed on
Sion Attend r death. ector: by the f	cati	2 Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (St	reet and Number or F	Rural Route Number, City Sty Meadow
Divis	Certification:	3 X Suicide 6 Could not be determined (Specify) residence	or Town, Sta Terrace	Germantow	n, MD
Hospi 24 hou Funer tely fil		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and control one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at	due to the cause the time, date a	(s) and manner as stand	ated. the cause(s)
To the within To the comple	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (M	
12-Per		O.C.M.E.		May 28, 2009	
		30. Name and address of person who completed cause of death (Item 23a)			
OGME		Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	21201		
	tate	TERM IN THIS TO ARRANGE TO THE TOTAL PROPERTY.			
Regis	uteli	OOIS O- LOVE /			

		-	For State Registrar	State of Ma		ertificate of D			ene 009	17939
			Decedent's Name (First, Middle	, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physicia	_	WILLIAM	WALTER	DOTSO	N SR.			19 2009	12:40 P ^M
	/Medic Examin		4a. Facility Name (If not institution	, give street and number)		4b. City, Town, or	Locetion of Death		4c. County of Death	
			7255 LEWIS L			WILLA			WICOMIC)
	Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birthda 77 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign intry)
	Director		236-44-9889	12.11.20.	77 Yrs.			MAY 28,	1931 WE	ST VIRGINIA
	and **		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	f sho	ō	MARYLAND WICO	MTCO	WILL	ARDS				1 X Yes 2 ☐ No
	the 28e	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	intry?
	3e or	Ö	7255 LEWIS LA	NE		21874			USA	
	death ms 2	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 1	3. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
9	or Ite	Ē	1 ☐ Never Married 2 Marr	ied 1.XXYes 2.□I	No	1 ☐ Yes 2 No	Specify:	,	Specify: WH	
21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or Items 23e or 28e-f show hedical Exar, it ar must be notified at	d by	3 Widowed 4 Divorced							
5	72 h "netu	Completed	15. Deceden (Specify only highe	t's Education st grade completed)	(Gi	cedent's Usual Occupa ve kind of work done d . DO NOT use retired)	uring most of worki		6b. Kind of Business/I	ndustry
121	vithin ne. han	Ig I	Elementary/Secondary (0-12)	College (1-4or	5+)	CHIEF	,		US NAVY	
7	e filed within al Hygiene. I other than 'vent, tre Me		17. Father's Name (First, Middle,	Last)			18. Mother's Name	(First, Middle, M	faiden Sumame)	
Maryland	d be intal li	9 Be		OTSON			LENORA	SV	WIGER	
<u>Z</u>	2 should be and Mental is marked of sumetic eve	၉	19a. Informant's Name/Relations	hip (Type, Print)	19b. Ma	iling Address (Street a	and Number or Rura	al Route Number,	City or Town, State, Z	ïp Code)
	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hyglene. If Health and Mental Hyglene item 23e or 28e-f show item 27 is marked other than "neturel", or Items 23e or 28e-f show other treumetic event, the Medical Exal it at must be notified at		HILDA M. DOTSON	/WIFE	7255	LEWIS LAN	E, WILLAI	RDS, MAR	YLAND 2187	4
Baltimore,	s 1 and 2 f Health item 27 i		20a. Method of Disposition			position (Name of rematory or other place		Date 2	20c. Location - City or	Fown, State
Ë	Page sent o nt: If ry or		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		CREMATO	RY OF DELMA	ARVA 5/2	1/09	DELMAR, DE	
alti	permit. Pages Department of It Importent: If ite any injury or of		21. Signature of unitral Service	Licensee	2	22. Name and Addres	-			
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ğ	death a atter	clai	in the past 12 months?	4☐Pregnant a	2 Fetal death it time of death	3 □Ectopic pregnancy 5 □ Other (specify)			Month	Day Year
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	To the Hospitel or Attend within 24 hours after death To the Funerel Director:	edical	(Check only 2 Medica	Examiner: On the basis and manner s	of examination and/o	r investigation, in my o	pinion, death occur	rred at the time, d	ate and place, and du	to the cause(s)
	o the	₹	29b. Signature and title of certification	er		29c. Licens	e number	2	9d. Date signed (Mon	th, Day, Year)
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	Regist	rar	MAY 2	2009 Lone	m B. H	garra				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	/Medic Examin	200	4a. Facility Name (If not institution, give street and nu	mber)	4b. City, Town, or	Location of Death	11004	4c. Count	ty of Death		
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ij. Ţ	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	, Year)	Coun		
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1	illed within 7.2 frouts after beant with the inary and stripene. why than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	Funeral	11. Marital Status 12. Was Dec Armed F	redent Ever in U.S. 13. orces?	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Ra Bla	ace - America ack, White, e		
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3	Menta Menta rrked rrice	2	Theodore Martin Myers			Helen Ir	ene Mar	shall			
	and land ls ma		19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ng Address (Street	and Number or Rui	al Route Numbe	er, City or Tow	n, State, Zip	Code)	
. 1	and lealth m 27 her tr		Marlin Durbin (son)	20b. Place of Dispo	3 Lappans		rplay,	MArylar 20c. Location			
	rages in nent of H ant: If ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from	State cemetery, cre	matory or other plac	e)			•		
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[2		30. Name and address of person who completed cau	use of death (Item 23a) (Type	, Print)			./.		2009 N MD 2174	
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	Sta Regist		31. Date filed (Morth, Ray, Marin) 32.	Registrar's Signature	to an						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Michael Wayne DELOSIER /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City. Town, or Location of Death Examiner Washington Hagerstown Washington County Hospital 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ₩ M 2 🗆 F 219-60-2569 1952 Jan. Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-4-1-30 injury or other traumatic event, the Maryland once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1X Yes 2 No Completed by Funeral Director Maryland Washington Funkstown 10g. Citizen of What Country? U.S.A. 10f. Zip Code 10e. Street and Number 21734 212 West Side Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No 197 14. Race - American Indian 11 Marital Status 1970-1 ☐ Never Married 2 ☐ Married white 1 ☐ Yes 2K No If Yes, Give Year or Dates: Specify. 1974 3 ☐ Widowed 4 X Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) freight transportation dock checker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wallace Sanford Delosier Virginia Elizabeth Henson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17932 Garden Lane Apt 23, Hagerstown, Maryland 21740 Micah J. Delosier - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 27, 2<u>009</u> 1⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State Hagerstown, Maryland 4 Donation 5 Dother (Specify) Rose Hill Cemetery Minnich Funeral Home Signature of Funeral Service Licenses 22. Name and Address of Facility 415 East Wilson Blvd., Hagerstown, Maryland 21740 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or conshock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient ٩ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature an 22 09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) redical Cumpes Rd MO N larek 11110 M 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year 30 2009 9:18A IRENE MARGARET IAY FOX /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK | Trunder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 1, 1917 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2√2 F Maryland 216-80-5926 92 Director Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Frederick Maryland Frederick 1 ☐ Yes 2X No of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f stoother traumatic event, I'm Medical Exprise must be notified. Director 10e. Street and Number 10f. Zin Code 10g, Citizen of What Country? 21701 U.S.A. 6101 Meadow Road Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐ No Specify: White þ 3√ Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Arthur Cromwell Cora Hamilton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4930 Roop Road, Mt. Airy, MD 21771 Mr. C. William Knill, nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If iter any Injury or ott once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet Cemetery June 3, 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal of Fun (al Service Lio na ²² Name and Address of Eacility Keeney and Basford PA Funeral Home M00255 106 East Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory armst shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Urin resulting in death) /Medical Due to (o, as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sonsequence of) Examine this certificate has been signed by the attending physician and al director, page 2 should be detached for use as the burial-transi Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknows 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To he Hospital or Attending Phy in 24 hours after death. he Funeral Director: After this pletely filled in by the funeral d 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day, Year) 1 Natural 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

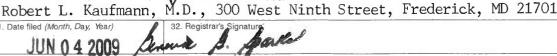
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely

W

To the within 2

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature as



ause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

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gair	permit. Pages Department of Important: If i any Injury or once.		21. Signature of Eneral Bervice Cicensee Memorial Gardens 2009 Frederick, 22. Name and Address of Facility Resthaven Funeral Services, Skkot Co													
_	₫ Q E 8 0		9501 Catoctin Mtn. Hwy. Frederick, I 23a. Part1. Enter the disease) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,										MD 2170			
			shock, or heart failure. List	only one cau	s that caus se on each	ed the death line.	n. Do not en	ter the mod	e of dyin	g, such as	cardiac	or respiratory	arrest,		Approxima Interval Be Onset and	tween
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	executed n and al-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С												
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0/00	ficate phys s the	Physician/Medical		d												
XOO	n certi inding use a	N/M	IF FEMALE: 23b. Was decedent pregnant			ne of <u>pregna</u>								23d. Date of o	elivery	
D	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4 [Pregnant	2 ☐ Fetal at time of d		☐ Ectopic p ☐ Other <i>(</i> s <i>p</i>		/				Month		Year
7	at the	hys	9 ☐ Unknown		Unknowr											
Ď,	res th signed	þ	Part II. Other significant condition	•	ng to death	but not resu	ulting in the u	nderlying ca	ause give	en in Part I.					to the cause of	
cords	w requir s been s should	eted	HTN											/	Probably 4 🗌	
ב ב	Attending Physician: The law redeath. ector: After this certificate has by the funeral director, page 2 s	Completed		1-		^ '						24a. Was			autopsy findings o completion of	
NI G	in: The tifficate or, pay	ပ္ပို	25. Was case referred to medica			(), X	321			00 51	10	1 ☐ Yes	2 7		es 2 No	
>	ysicia s cert direct	To Be	examiner?	Hospita	l: 1□ Inna	tient 2□	ER/Outpatie	nt 3 🗆 DC	Othe	or.		h <i>(Check only</i>		6 ☐ Other (Si	200164	
5	ig Phy ter thi neral o		27. Manner of Death		. Date of Ir (Month, E	jury	28b. Time o		8c. Injury Work		rsing ric	28d. Describe			Jecny)	
5	endin sath. or: Af he fur	atio	1 Natural 5 Pendin investig	gation	(MOMIN, E	ay, reary	mjury	М		Yes 2 □ I	No					
Ě	or Att fler de firecte n by t	Certification:	3 Suicide 6 Could 4 Homicide determ		. Place of I building,	njury - At ho etc. <i>(Specif</i>)	me, farm, st	eet, factory	office	-		28f. Location City or To	(Street a	and Number or te)	Rural Route Nur	nber,
ַ	pital ours a eral c		29a, Certifier	a Physician	To the her	et of my know	wladao doo	h conversed	at the tim	na data au	d -loss			(-)		
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burneral director.	Medical	(Check only 2 Medical one)	Examiner: O	n the basis	of examinat	tion and/or in	nvestigation	, in my o	pinion, dea	th occur	red at the time	, date ar	(s) and manner nd place, and d	ue to the cause(s)
	To the comp	Me	29b. Signature and title of certifie	·						number			29d. D	ate signed (Mo		
			muns	(ren	4,14	0			04	62	48			5)18	109	
B	5	Ì	30. Name and address of person			death (Item	23a) (Type,	Print)								
7	Stat Registra		31. Date filed (Month, Day, Year) NAY 19 2	009	3e. Regis	trar's Signa	ture	Kel								

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				partment of Health and Menta	al Hygiene
44	Physici /Medi Examir	cal	1. Decedent's Name (First, Middle, Last) MARY (ATHERINE FOLTZ - 4a. Facility Name (If not institution, give street and number)	Mc	te of Death onth Day Year 3. Time of Death onth 2009 15:59 M
	Examin	ier	The Johns Hopkins Hospital	Baltimore City	N/A
l.	Funeral Director		5. Social Security Number $\begin{array}{c ccccccccccccccccccccccccccccccccccc$	Months Dave Hours Min (M	te of Birth onth, Day, Year) y 3, 1948 9. Birthplace (State or Foreign Country) Maryland
	yland Jow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Le	ocation	10d. Inside City Limits
	Ra-f sh tified a	Director	MD Washington Hagerst	own	1 ☐ Yes 2 X] No
	with t		10e. Street and Number 11106 Lakeside Dr.	10f. Zip-Code 21740	10g. Citizen of What Country? U.S.A.
036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	1 Never Married 2 X Married 1 Yes 2 X No	Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican, 1 ☐ Yes 2 X No Specify:	
21215-0036	within 72 ho lene. than "natur he Medical I	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation hind of work done during most of working DO NOT use retired) ctor/Advisor	16b. Kind of Business/Industry Education
	be filed tal Hygi d other event, tl	Be C	17. Father's Name (First, Middle, Last)		, Middle, Maiden Surname)
Maryland	2 should be f and Mental I Is marked ol aumatic ever	욘	Richard Kuhlman 19a. Informant's Name/Relationship (Type. Print) 19b. Maili	Hattie Mae	
, Ma	1 and 2 s Health ar em 27 ls ither trau		Kenneth Lee Needy/Husband 1110	6 Lakeside Dr., Hager	
nore	Pages 1 nent of H nrt: If iter iry or oth		125 - and 2 - and and and an analysis of the state	matory or other place)	20c. Location - City or Town, State
Baltimore,	permit. Pages Department of Important: If i any Injury or once.		21. Signature of Funeral Service Licentee 2	en Cemetery 5/26/200 2. Name and Address of Facility Rest	9 Hagerstown, MD Haven Funeral Chapel
	9 2 E P 9		23a. Part 1. Enter the disease, or complications that caused the death. Do not en	601 Pennsylvania Ave.	
3	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	man a react	Interval Between Onset and Death
A	/Medical Examiner		resulting in death) Due to (or as a conso wence of):	and ones.	201
	n #	iner	Sequentially list conditions, if any, leading to firm ediate cause. Enter Underlying Cause (Disease or injury	in injury -	20 days
_	executer and al-trans	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last C. Very Cura Cartes Control of the Con	Fibrillation	20 days
1,60	certificate be executed ding physician and use as the bunal-transit	dical	Coronary Ar	tery Disease	10 years
O. Box 68	death certific	Physician/Me		Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year
J.	law requires that the as been signed by the 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23	Be. Did tobacco use contribute to the cause of death?
Records,	w requires that been signed I should be de	Completed		24	a. Was an 24b. Were autopsy findings available
=	a ju	Com		1[autopsy performed? prior to completion of cause of death? ☐ Yes 2 No 1 Yes 2 No
Vital	sician: certific		25. Was case referred to medical examiner? 1 □ Yes 2 No Hospital: 1 1 Inpatient 2 □ ER/Outpatien	26. Place of Death (Check	k only one) ☐ Residence 6 ☐ Other (Specify)
on or	Ing Phy frer this uneral c		27. Manner of Death 1 Natural 5 □ Pending (Month, Day Year) 28b. Time of Injury	of 28c. Injury at 28d. De Work?	escribe how injury occurred
DIVISION	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pages.	ertification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, structure building, etc. (Specify)		cation (Street and Number or Rural Route Number, or Town, State)
	e Hospita 124 hours e Funeral bletely fille	edical C	29a. Certifier (check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place, and due vestigation, in my opinion, death occurred at the	e to the cause(s) and manner as stated. ne time, date and place, and due to the cause(s)
	vithir Somp		29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Y	1/		30. Name and address of person who completed cause of death (Item 23a) (Type,	Res-000	May 20, 2009
					Wolfe St, Baltimore, MD, 21287
	Star Registra	C	MAY 2 6 3009	a. 4. 1	

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1, Decedent's Name (First, Middle, Last) May 17, **Physician** 2009 7:35A Joseph Anthony Freda /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel 231 Maryland Way Edgewater Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year 1/27/1918 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months Days Hours Min 1 X M 2 □ F 91 Massachusetts 027-09-2284 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Extending the mount to a rollined and injury or other traumatic event, the Medical Extending the mount of the contract of the mount of the mou 1 ☐ Yes 21 No Director Maryland Anne Arundel Edgewater 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21037 USA 231 Maryland Way Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 17 Yes 2 No WWII 1 ☐ Never Married 2 【 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: White þ 3 Widowed 4 Divorced Ye ar or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Bicycle Shop 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Freda Fortuna Troiano Unknown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 231 Maryland Way Edgewater, MD. Dorothy Mae Freda/Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🕅 Burial 2 □ Cremation 3 □ Removal from State 6/4/2009 Arlington, Virginia Arlington Nat. Cem. 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home of Funeral-Service Licenses 21. Signatu alas 2973 Solomons Island Rd. Edgewater, MD. 21037 23a. Part 1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one raise on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician resulting in death) /Medical Du vo (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Je. The law requires that the death certificate be executed attending physician and for use as the burial-transit Examil that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Year Day 1 ☐ Yes 2 ☐ No 9 D I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🔲 Yes certificate has been s irector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director; After this certificatiely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home Hospital 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 1 ☐ Yes Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide 24 hours a 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

139 012

Solumns Island Rd. Annopalis MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAY 19

mund

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () () 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 20ay Nancy Louise Graham 3:40 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Frederick Frederick Frederick Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 💢 F Maryland 213-42-1347 67 May 30, Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If them 27 is marked other than "natural", or Items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show the Medical Evantines must be notified at 1 ☐ Yes 2 No Director Maryland | Frederick Myersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10553 Highland School Road 21773 USA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 "natural", or 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☒ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bus Driver Transportation permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 Is marked other any Injury or other traumatic event, I Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hezekiah Elmer Baker Catherine Viola Dutrow ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Daniel Graham/son 20931 Twin Springs Drive, Smithsburg, MD 21783 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory June 1, 2009 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 504 Main Street 22. Name and Address of Facility Ricketts Funeral Home Myersville, MD 21773 23a. Part I. Ent.: the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Muscendla /Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Be Completed by Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Lectopic pregnancy Month Year Day 5 ☐ Other (specify) been signed by the s should be detached f 1 ☐ Yes 2 🗷 No P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 図 Unknown DDN 24b. Were autopsy findings available prior to completion of cause of death? ours afer death.

I teral Director: After this certificate has I filled in by the funeral director, page 2 s 24a. Was an MAN 1 ∐ Yes 2 SNo 1 ☐Yes 2 ☐No LAID 25/Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2 MNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a

To the Funeral I 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MDD47535 30. Name and avor ey person who completed cause of death (Item 23a) (Type, Print) 1564 Oppssumtown PK Frederick, MD 21702

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State

Registrar

Kimanh 31. Date filed (Month, Day, Year,

JUN 0 4 2009

32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician 2009 May 17, 12:25P [™] Jean Whitney Groo /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel 2675 Cunningham Hole Road Annapolis 9. Birthplace (State or Foreign Country) New York If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8/24/1923 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🗓 F 85 New Director 072-18-3252 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Expression 2000. 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 ☐ Yes 2 X No Funeral Director Maryland | Anne Anne Annapolis 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2675 Cunningham Hole Road USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No Specify: White þ 3 X Widowed 4 ☐ Divorced Be Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Whitnev Helene Yenney ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Stephen W. Groo/Son 1037 Diamond Drive Churchton, MD. 20733 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Marcremation 3 ☐ Removal from State 5/18/2009 Edgewter, Maryland 5 ☐ Other (Specify) Kalas Crematory 4 Donation 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service Licensee 2973 Solomons Island Rd. Edgewater, MD. 21037 2.4. Par/1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Lung Cancer yrs. disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Emphysema 20 years Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or injury that initiated events. Due to (or as a consequence of): Examiner the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 pionths?
1 ☐ Yes 2 A No
9 ☐ Unknown Month Dav Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No ⊺∐Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 1 Nursing Home | 5 \(\text{Residence} \) Residence | 6 \(\text{Other} \) Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

To the Hospital or Attending Physiclan; The law requires that the death certificate be executed Box 68760, Division of Vital Records, P.O. Certification: To after death.

I Director: After this d in by the funeral d

1 Yes 2 No 27. Manner of Death 1 Natural

> 2 Accident 3 Suicide

5 Pending investigation 6 ☐ Could not be

4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

28a. Date of Injury (Month, Day, Year)

D 0050331 05/18/2009 Print) 21401 TIDEWKER COLONY DR. ANNAG. LIS MA.

28c. Injury at Work?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2009 MOMA

31. Date filed (Month. Day.

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

e Funeral

To the I

Medical

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2009 May 8:02 P. M Greenfield Betty Α. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 3500 Sandy Court Kensington nder 1 Year | If Under 24 Hrs. Montgomery 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year 8. Date of Birth (Month, Day, Mar. 3, Social Security Number 7. Age (In yrs. last birthday) Days Year) 24 Hours 1 □ M 2 🖵 F 85 Yrs 195-16-4732 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Yes 2 No Kensington Maryland| Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U. S. A. 20895 3500 Sandy Court 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 □Yes 2KNo Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse 2 Years Nursing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruth Stambaugh Norman L. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marvin H. Greenfield - Husband 7215 Selkirk Drive, Bethesda, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Falls Church, Virginia King David Mem. Gdns | 5/22/2009 21. Signature of Funeral Service Licensee Edward Sage Funeral Direction, Inc.

Physician /Medical

Physician

Examiner

Funeral

Director

ral", or items 23a or 28a-f shore

Directo

Funeral

<u>6</u>

Completed

Be

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/Medical

Examiner

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician: 24 hours after death,

To the Hospital within 24 hours a To the Funeral C

Donald C. L	tottlenger"	1091	Rockville Pik	e, Rockvill	le, Maryl	and 20852
23a. Part 1. Enter the disease, or com shock, or heart failure. List only						Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition	Pulmonar	y Fibrosis				Onset and Death
resulting in death)	Due to (or as a consec	quence of):				
Sequentially list conditions,	Hypoxia b					
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	the second secon	ai luro			
that initiated events	C	ve Heart F	ariure			
resulting in death) Last	Due to (or as a consec	quence of):				
	d. Rheumato	id Arthrit	is			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Yes 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 Ectopic			23d. Date of deli Month	very Day Year
Part II. Other significant conditions	contributing to death but not res	sulting in the underlying	cause given in Part I.			the cause of death?
				24a. Was an autopsy performed 1 🗆 Yes 2	prior to o	topsy findings available completion of cause of 2 No
25. Was case referred to medical examiner?			26. Place of De	eath (Check only one)		
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatient 3 ☐ I	DOA Other: 4 \sum Nursing	Home 5 🔀 Residence	6 ☐ Other (Spec	cify)
27. Manner of Death 1 ★Natural 5 ☐ Pending 2 ☐ Accident investigatio		28b. Time of Injury	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in	jury occurred	
3 Suicide 6 Could not be determined		nome, farm, street, factorify)	ory, office	28f. Location (Street City or Town, St		ral Route Number,
29a. Certifier 1 Certifying P	hysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, death occurre ation and/or investigati	ed at the time, date and place on, in my opinion, death occ	ce, and due to the cause curred at the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)
20h Signature and title of cartifier		2	9c License number	204	Date signed (Month	Day Year)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue, #101, Bethesda, Maryland 20814 Collin D. Cullen, M. D. 7625 Wisconsin Avenue, #101, Bethesda, Maryland 20814

MD0052247

May 18, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 Day Month **Physician** 915 am ma /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number)

PLEASHUT VIEW NURSLING HIME

4 10 1 0 LD NATONAL RILE Examiner ARROL MAUNI If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav) 5. Social Security Number **Funeral** Months Days Hours Min 1 X M 2 □ F June 4, 1920 Director 88 Tennessee 414-18-0109 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 1 ☐ Yes 2 No "natural", or items 23a or 28a-f sh dical Examiner must be notified Director Maryland Howard Mount Airy 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number 4101 Baltimore USA Funeral filed within 72 hours after death Hygiene. Ither than "natural", or items 23 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:1941-1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🕱 No Specify: Specify þ 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien. Important: If Item 27 Is marked other traumatis. 5+ Technical Writer Electronic Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Tennessee Fergusion Joseph Hughes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4216 Buttonwood Road, Fort Worth, Texas <u> 76133</u> Melvyn Hughes, son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5/24/2009 4 Donation Clarksburg Methodist Cemetery Clarksburg, Maryland 5 Other (Specify) 21. Ignature of Fuseral Service Lice 22. Name and Address of Facility Molesworth-Williams Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. F te the disease, or complications that chused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or h art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or vondition resulting in death) Physician MYOCARDIAL INFARCTION 20 /Medical Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner Joan The law requires that the death certificate be executed perturion Due to (or as a consequence of): tt Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1□Yes 2□No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 DERENTIA 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed orteo authoritis 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☑No 24a. Was an certificate has autopsy performed? Yes 2 No 1☐ Yes ospital or Attending Physician: Thours after death.

Ineral Director: After this certificate filled in by the funeral director, pa 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tyes 2 No 1 | Inpatient 2 ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manuer of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 18,2009 -30469

DHMH 17 Rev 1/2001

4+1

State Registrar 31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760.

Division or Vital Records, P.O.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PARKWAY: #308, COLUMBIA, MD. 21045
N.B. VELLANICI, 8850 COLUMBIA 100 PARKWAY: #308, COLUMBIA, MD. 21045

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 7:55PM 200° Charles Burton Heath ma /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington County If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Nov. 27,1960 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1**X** M 2□ F 227-76-9038 Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h Counts 28a-f show 1 ☐ Yes 2 No Director Frederick County Middletown Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or 2 U.S.A. 21769 Funeral 6229 Harley Rd. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2√2 No Specify Specify: White by 3 ☐ Widowed 4 ☐ Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Item Maonce. Elementary/Secondary (0-12) College (1-4or 5+) Distribution Center Bulk Selector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Belle Hare Heath Frank Burton Heath 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6229 Harley Rd. Middletown, MD 21769 Beverly Heath-wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-26-2009 Smithsburg, Maryland Smithsburg Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Douglas A. Fiery Funeral Home 1331 Fastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARDIA **Physician** INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner cronse Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Be Completed by Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation within 24 hours are. To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 5/24/09 30 Name and addressed person who completed cause of death (Item 23a) (Type, Print), treet NW Kenneth M. H. Lee 2021 K. Darret NW SUITE 315

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 27

32. Registrar's Signature

			For State Registrar		Sta	ate of	Maryla		epartmer Certificat				lental Hy	giene Reg. No	2000	17951	
	Physicia	an	1. Decedent's Nam	, ,	e, Last)								2. Date of De Month	Da		3. Time of Death	
	/Medic	al -	Ivan Gor		- she street	and num	ab au		4h City	Town or	Location (of Death	MAY	25	2009 . County of Deat	9:00P.M.	•
· ·	Examin	er	4a. Facility Name (Reeder's 1		-	ano num	iber)			nsbon		or Death			shington		
	Funeral		5. Social Security !	Number	6. Sex		7. Age (In yrs	s. last birth		r 1 Year	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	rth		hplace (State or Foreign untry)	
- 8	Director		215-14-25		X ^M 2	2∐ F	86	Yr	s.	Days	Tiouis	IVIII I.	Jan. 30,	1923	Maryl	and	_
	and w		Usual Residence of 10a. State	of Decedent 10b. County			10c. C	City, Town o	r Location							10d. Inside City Limits	_
	Maryl -f sho fied a	tor	Maryland	Washin	gton Cou	inty	Ha	gersto	wn							1 □Yes 2 No	
	th the or 28a e noti	Funeral Director	10e. Street and Nu	umber					10f. Zi	p Code				10g. Ci	tizen of What Co	untry?	
	ath wi	rai	335 Dayco	tah Ave.					217						S.A. 14. Race - Ame	rican Indian	
	ter de items iner m	-une	11. Marital Status 1 ☐ Never Mar	ried 2□ Mar	l Ai	rmed For	dent Ever in ces? 2 □ No	U.S.	If Yes, sp	ecify Cuba	an, Mexica	n, Puerto	ecify Yes or No Rican, etc.)	0-	Black, White		
036	urs afi al", or Exami	by	3 ₩Widowed		i if	Yes, Giv ear or Da	² □ No e _{tes:} 1943-	1946	1 ☐ Yes	2 No	Specify:	•			Specify: Wh	ite	
}√ 5-0036	72 hours after death with the Maryland 'ratural', or items 23a or 28a-f show dical Exar⊓iner must be notified at	eted	(Spe	15. Deceder	nt's Education	n npleted)		16a. D	ecedent's Usi Give kind of wife. DO NOT to	al Occup	ation during mos	st of work	ing	16b. K	(ind of Business/	Industry	
2121	within ene. than "	Completed	Elementary/Sec	ondary (0-12)	C	ollege (1	-4or 5+)		et Metal		a)			Sand	l Blasting	Mfg. Co.	
D 2	filed v Hygie	e Co	17. Father's Name	e (First, Middle	. Last)						18. Moth	er's Name	e (First, Middle	e, Maider	n Surname)		
lan 🧞	Jid be Jental rked c	To Be	Frank Hull	1							Nann	nie Mo	Comas Hu	11			
$\mathcal{L}_{\mathcal{L}}$	2 sho and ∄ is ma auma		19a. Informant's N			rint)		I	_						or Town, State, 2	Zip Code)	
AME: HULL, Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Jennifer Z		phter	-	20h		Daycota Disposition (Na		. Hage		n, MD 21 Date		ocation - City or	Town State	_
٥٥	ages 'nt of H I: If ite		1 🖫 Burial 2	□Cremation		val from S	State	cemetery,	crematory or	other plac	1				-		
/7) =	nit. P artme ortani injun		21. Signature of F	5 Other (Re	est Hav	en Cemet 22. Name a			5-29-			rstown, M y Funeral		_
E 88	Dep Imp any		NOU	eurs	N	Z	zinu		1331 Ea	stem	Blvd.				MD 21742		
2	* *	1	23a. Part1. Enter shock, or he	the sease, c	r con plication t only one car	ns thu ca use on ea	aused the de ach line.	ath. Do no	t enter the mo	de of dyin	ng, such as	s cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death	
	Physician	///2	Immediate Cause disease or conditi	ion	a.		Ani	teno	sun	لاخ	صر	elis l	ance	, D.	nen	75	
	/Medical Examiner		resulting in death)	,		Due to (or as a cons	equence of):								
-		er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):												_		
	ate be executed hysician and he burial-transit	Examiner	Cause (Disease or injury that initiated events c														
760,	te be executed ysician and e burial-transit		resulting in death) Last Due to (or as a consequence of):														
3876	icate b physic the b	dical			d												_
Division or Vital Records, P.O. Box 68	Attending Physician: The law requires that the death certifica rdeath. ector: After this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decede	ent pregnant			come pf preg								23d. Date of de	livery	
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co	ie law requires t has been signe ge 2 should be c	letec									-		24a. Wa	s an	24b. Were a	utopsy findings available	
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o uc	ding F	ion:	27. Manner of Dea	5 Pendi		Ba. Date ((Mont	th, Day Year)	28b. Ti Inj	ury M	28c. Injur Wor 1 □	ryaτ rk? ∣Yes 2 [¬No	28d. Describe	e now inj	ury occurred		
/isi	Atten	ficat	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could		Be. Place	of injury - At	home, farr	n, str <i>ee</i> t, facto							ural Route Number,	
Ę	tal or safter safter al Dire	Certification: To	4 Homicide	,		Dullai	ng, etc. (Spe	:сну)				ļ	City or T	OWII, SIA	<i>(e)</i>		
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one)		I Examiner:	On the b									s) and manner a nd place, and du	s stated. e to the cause(s)	
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	Sta Regist		31. Date filed (Mo	MAY 2		32. F	egistrar's Siç		back								

DHMH 17 Rev 1/2001

ORIGINAL

09-04073 Evan Hollis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physicia al Exami		Evan Anthony Hollis Month Day Year May 22, 2009											
		4a. Facility Name (if not institution, give street and not 158 East Main Street	cation of Death		4c. County of De Carroll	eath							
Funeral Director		5. Social Security Number 6. Sex 214−83−5223 1 M 2 F	7. Age (In yrs. last birth	hday) Yrs.	Months Days 7	If Under 24Hrs Hours Min.	⊣	Foreign Maryland					
nd show any ice.	J.	Usual Residence of Decedent 10a. State 10b. County Maryland Carroll	10c. City, Town o	or Locatio		Westmin	ster		10d. Inside City Limits 1 XYes 2 No				
uth the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 158 East Main Street			10f. Zip Code	21157	10g.	Citizen of What C	Country? USA				
r death w	Funeral	11. Marital Status 1 Never Married 2 Married Armed F 1 Yes 3 Widowed 4 Divorced If Yes, Give Ye	2 X No	If Ye	Decedent of Hispa s, specify Cuban, N	Mexican, Puerto		White, etc	nerican Indian, Black, c. white				
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tal Hygiene. ked other th	Be Comp	N/A 17. Father's Name (First, Middle, Last) Josh Evan Acampa			N/A		(First, Middle, Mai in Irene		A				
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permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic ev		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal f 4 Donation 5 Other Specify:	Winfie	City or Town, State									
Depart Importing National Nati	d	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funera 91 Willis Street, Westminster, MD 21 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart											
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er death. rector; After 1 by the funeral	Certification:	27. Manner of Death Natural 5 Pending 2 Accident Investigation 3 Outstand 5 X Could act has a second representation 2 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred											
within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide Certifier (Check only 1 Certifying Physician: To the be	resideno	ce th occurre	ed at the time, date	and place, and	or Town, Stat Westmins due to the cause(s	e) 158 En ter, MD	Main St stated.				
within comple	Medical	one) 2 Medical Examiner:On the basis and manner s		nvestigatio	29c. License r	number	OCME 2	9d. Date signed	(Month, Day, Year)				
O W.33		30. Name and address of person who completed cau Theodore M. King, Jr., MD. Assista	_	r)	O.C.M.		OCME 1 e, MD 21201	May 23, 2009 					
			ant Medical Exami										

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 8:54 PM 16. 2009 MAY VAUGHAN T. HARFORD, JR. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Edgewater 3594 Loch Haven Drive Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 X M 2 ☐ F DC 90 Washington, 10/7/1918 577-12-1377 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City. Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it we Medical Exaction or other traumatic event, it we Medical Exaction or other traumatic event, it we Medical Exaction or other traumatic event, it we medical Exaction or other traumatic event. 1 □Yes 2 XXIo Director Edgewater Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3594 Loch Haven Drive 21037 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: 1941-45 14. Race - American Indian Black, White, etc. 11 Marital Status 1 Never Married 2 Married White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify 2 3 ☐ Widowed 4 ☐ Divorced Completed 16h. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Patent Office 4 years Patent Attorney 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine M. Schwab Vaughan T. Harford, Sr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3594 Loch Haven Drive, Edgewater, Maryland 21037 Lee S. Harford/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/18/09 Edgewater, Maryland Kalas Crematory 22. Name and Address of Facility 21. Signature of Juneral Solvinge, George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the l If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death for use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) □Yes 2□No detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u></u> 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has 1 ☐ Yes 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 Wo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? After Injury Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determ 4 Homick er ying in sician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

It ical iner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a / ertifier To the P within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of ce D58166 Eric C. Marcalus, M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite Braverton 101 Kokewster

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 18

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month Day Rowena Leva Huggins 14, 2009 6:35 PM May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10713 Fingerboard Frederick Road Ijamsville 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Months Days 129-18-4479 Sept.8 90 ,1918 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Evantible mat be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits I jamsville Funeral Director MD Frederick Yes 2□No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 10713 Fingerboard Road 21754 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2€ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Be Completed by Specify: Black 3€ Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Child Care Elementary/Secondary (0-12) College (1-4or 5+) Self-employed Provider 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Samuel Claggett Mary Snowden ౖ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Woodley (Daughter) 1410 Baker Pl.West #13, Frederick, MD 21702 20b. Place of Disposition (Name of cematery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 3☐ Cremation 3 ☐ Removal from State Ardent Crematory 5/19/09 4 ☐ Donation 5 ☐ Other (Specify) Hanover, MD 21. Signature of Funeral Service 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart fallule. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Lung Cancer year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ursease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical as the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Vear 5 Other (specify) signed by the a 1 ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Yes 2 No 3 Probably 4 Unknown icate has been si page 2 should t Emphysema Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 XNo 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this funeral of 27. Manner of Death Date of Injury (Month, Day, Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: d in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours after To the Funeral Dir 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Defined Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

20

Austin Pearre, Jr, M.D. 300 W. 9th Street, Frederick, MD 21701

24114 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2009

Registrar's Signature

D09689

5/18/09

Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit

ords, P.O. Box 68760,

Division of Vital Rec	To the Hospital or Attending Physician: The law within 24 hours after death.	To the Funeral Director: After this certificate has	completely filled in by the funeral director, page 2 s	
DH	MH 1	Re 7 R	gis ev 1	ita

	1 - State Registrar Certificate of Death Reg, No.																
	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year													3. Time of Death			
an cal	Wojciech Peter Janicki May 19, 2009														15 PM		
ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Bethesda Montgor													ery			
	5. Social Security N 027–24–7		6. Sex 1 XM 2 ☐ F	7. Age (In yrs.	last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nonths Days Hours Min. Apr 5, 1929							Cot	Birthplace (State or Foreign Country) Coland				
	Usual Residence of	Decedent															
	10a. State	10b. County	у	10c. Ci	ty, Town or L	ocation								10d. Inside	City Limits		
Funeral Director	MD		gomery	Bet	hesda	106 7	ip Code				10=	Citizan of	Mhat Car		es 2 XNo		
늅	10e. Street and Nur											. Citizen of	winat Cot	and y :			
<u>ra</u>	10305 Fa	ırnham	Drive			208					US	SA					
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ğ	3 Widowed	4 🔲 Divorce	d Year or	Dates: 1952	-54	I 🗆 i e s	2 2 1110	Specif	у.			Specii	y: Whi	te			
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Completed by	Elementary/Seco	indary (0-12)	College 5+	(1-4or 5+)	Resea	rcher		1)			υ.	S. In	form	ation	Agency		
Be C	17. Father's Name	(First, Middle	, Last)					18. Moth	ner's Nam	ne (First, Mic	ldle, Ma	iden Surnar	ne)				
To B	Zygmunt	Janick	xi.					Zof	ia Su	ırmace	wicz	3					
-	19a. Informant's Na					-						-		te, Zip Code)			
	Wanda J.	Janio	cki/ wife		1030	5 Far	nham	Dri	ve Be	ethesd	a, N	1D 208	314				
	20a. Method of Disp		3 Removal from	n State	Place of Disp ce <i>metery,</i> cre	ematory or	other place			Date	20	c. Location	- City or T	City or Town, State			
	4 □ Donation			W.	Arund	lel Cr	remat	ory	05/2	21/09	Oc	denton	, MD	MD			
	21. Signature of Funeral Service Licensee Colling Tionies C.Femiliation Service P.O.). Bo				
	Her	els d	L. Hell	MO MO	1251 B	ever]	y L.	Hec	krott	te, P.	A. (Clarks	vill	e, MD	21029		
	23a. Part 1. Enter to shock, or hea	he disease, d	or complications that of only one cause or	t caused the deat	th. Do not er	nter the mo	de of dyir	ng, such a	s cardiac	or respirato	ry arres	t,		Approximate Interval Between			
	Immediate Cause disease or condition	(Final		eimer's	Diseas	e								Onset and Death Vears			
	resulting in death)	,,,,	a	o (or as a consec									-				
_	Sequentially list conditions, b																
/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury																
Exar	that initiated events resulting in death) I	3	c	o (or as a conseq	uence of):												
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	IF FEMALE: 23b. Was decedent	t pregnant		utcome of pregn								23d. Da	ate of deli	delivery			
cia	in the past 12 1 □Yes 2 [months?		e birth 2 🗆 Feta egnant at time of		☐ Ectopic ☐ Other (s		у			_	M	onth	Day	Year		
Jysi	9 Unknown		9 □ Un	known													
Y P	Part II. Other signit	ficant condit	cions contributing to	death but not res	sulting in the u	underlying	cause giv	en in Part	t I.	23e. [oid toba	cco use con	tribute to	the cause of	of death?		
Completed by Physicia										1	□Yes	2∕∑ No	3 ☐ Pro	obably 4[Unknown		
plet											Vas an utopsy	24b.	Were au	topsy finding	gs available		
ĕ										1 🗆 Y	erforme	rd? S No I	death? 1 ☐ Yes				
ě	25. Was case refer	red to medica	al					26. Pla	ce of Dea	th (Check or							
0	examiner? 1∐Yes 2⊠X	No	Hospital:	Inpatient 2] ER/Outpatie	ent 3 🗆 🗅	Oth	er: 4 🗆 t	Nursina H	ome 5 F	Residen	ce 6 □Ot	her (Spec	cifv)			
T:U	27. Manner of Deat			te of Injury onth, Day, Year)	28b. Time o	of	28c. Injur					injury occu					
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Ce		.Ma															
Medical Certification: To Be	29a. Certifier (Check only one)	1 ☑ Certifyi 2 ☐ Medica	ing Physician: To t il Examiner: On the and ma	he best of my kno basis of examina anner stated.	owiedge, dea ation and/or i	ith occurre investigatio	or at the ti on, in my o	me, date opinion, d	and place eath occu	e, and due to irred at the ti	me, dat	ise(s) and n e and place	nanner as , and due	stated. to the caus	e(s)		
Me	29b. Signature and	title of certific	er .	, 1	1 .	25	9c. Licens	e number	,		290	I. Date sign	ed (Month	n, Day, Year)		
	1	raul	he In	while	ul H		01978	5			Ma	ay 20,	200	9			
	30. Name and addr	ess of persor	n who completed ca	use of death (Iter	m 23a) (Type	, Print)	3 "	200			,	2005					
			al, M.D.	Andrew Cine				202]	Rockt	ville,	MD	20854	!				
ite ar	31. Date filed (Mon	MAY 2	1 2009	egistial's Signa	B. A	backs	1	•									

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Box 68760.

DHMH 17 Rev 1/2001

State

Registrar

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501

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 Kander

32. Registrar's Signatur

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 23,0009 Alton Henry KNIGHT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hagerstown

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year)

Months Days Hours Min. May 9, 1923 Washington

9. Birthplace (State or Foreign Country) Washington County Hospital . Age (In yrs. last birthday) **Funeral** Months 1 X M 2 □ F 86 West Virginia Director 232-26-5748 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Exeminer must be notified at 1X Yes 2 □ No Director Maryland | Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number Funeral 167 Chantilly Court 21740 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 If Yes, Give WW Year or Dates: 1 ☐ Yes 2 No Specify Specify: 2 TT White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) 8 Electrician Construction i. Pages 1 and 2 should be filed w tment of Health and Mental Hygie tant: If Item 27 is marked other t ijury or other traumatic event, Ib 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Clay Knight Lena R. Ambrose ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Diane Franks - Daughter 7807 Twin Stream Drive, Ellicott City, Md. 21043 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. 4 Donation 5 DOther (Specify) ¢edar Lawn Mem. Park 5/29/09 Hagerstown, Maryland Name and Address of Facility Minnich Funeral Home 21. Signature of runeral Service Licensee 5 E. Wilson Blvd. Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of pach line. Immediate Cause (Final disease or condition resulting in death) weik **Physician** /Medical Due to for as a consequence of **Examiner** eval YEARLS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence ob: Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.0. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed? certificate 1 ☐Yes 2 ☐No 1 ☐Yes 2 No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 🏻 Natural 1 ☐ Yes 2 ☐ No death. n 24 hours after death.

le Funeral Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) Verithin 2. and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 160 MO O'STAGINITUN RADIR 190 GHAMAN 31. Date filed (Month, Day, Year)

State

Registrar

MAY 2

			For State	State of Mai	-	epartment of Certificate of		Mental Hy		2020	17050
			Registrar 1. Decedent's Name (First, Middle, La	st)			Boath	2. Date of De		2009	3. Time of Death
	Physicia /Medic		Charles Wesley Ki	ght				May	16 ^{Day}	2009	12:25 P M
	Examin	er	4a. Facility Name (If not institution, giv	county of Death ne Arun	ıdel						
	Funeral		439 Birch Drive 5. Social Security Number 6. 8	Sex 7. Age	(In yrs. last birt	Edgewa	r If Under 24 Hrs.	8. Date of Bir	rth		place (State or Foreign ntry) Lngton, D.C.
	Director		577-32-5992 Usual Residence of Decedent	MM 2 L F	79	Yrs. Months Day	s Hours Min.	01/12/	1930	Washi	mgton,D.C.
	yland		10a. State 10b. County		10c. City, Town					1	10d. Inside City Limits
	e Mar 8a-f st	Director	Maryland Anne Aru	ındel	Ed	gewater					1 ☐ Yes 2 Å No
	with the		10e. Street and Number			10f. Zip Code 21037				en of What Cour ed State	
	death	Funeral	439 Birch Drive 11. Marital Status	12. Was Decedent Ev	er in U.S.	13. Was Decedent of	f Hispanic Origin? (S	pecify Yes or No		4. Race - Americ	can Indian,
36	172 hours after death with the Maryland "natural", or items 23a or 28a-f show adical Evarations be notified at	by Fu	1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give	•	1 □Yes 2 🕅 N	o nicari, etc.)		Black, White, Specify: Whi		
15-0036	2 hour		15 Decedent's F	Year or Dates:	16a.	Decedent's Usual Occ	upation		16b. Kin	d of Business/In	
121	within 72 ho jiene. r than "natur fr Modical	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	m	(Give kind of work don life. DO NOT use reti	e during most of wor red)	king	Con	structi	on.
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/lan	2 should be f and Mental Is marked of aumatic eve	To Be	Elmer M. Kight				Anna T.	Lee			
Maryland 2			19a. Informant's Name/Relationship (Anne Marie Kight	Type.Print) /Wife	1	Mailing Address (Stre. 9 Birch Dr					
<u>ب</u>	t and the Health tem 27		20a. Method of Disposition	/ WILE		Disposition (Name of y, crematory or other p.		Date Date		ation - City or To	
<u> </u>	Pages ment of I ant: If Ite ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 【 Other (Special	Removal from State	l .			1/2009	David	dsonvill	le MD
Baltimore,	permit. Pages Department of Important: If II any Injury or once.		4 □ Donation 5 ☑ Other (Special 21. Signature of Funeral Service Live	is de		22. Name and Add	ress of Facility Ge	orge P.	Kalas	s Funera	11 Home
	TT = 4 G		23a. Part 1. Enter the disease, or com	plications that caused the	ne death. Do n	2973 So1o		<u>.</u>		ewater,	Approximate
*	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line	CAL	ung					Interval Between Onset and Death
4	/Medical Examiner		resulting in death)	Due to (or as a	consequence o					/	W(VIV VIV)
		ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):								
	ocuted nd transit	Examiner	Cause (Disease or injury that initiated events	C							
28/60,	ificate be executed g physician and ss the burial-transit	al Ex	resulting in death) Last								
20	tificate ig phys as the	ledical		⊾d					3757		
ZOZ	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of		3 ☐ Ectopic pregna	ncy		2:	3d. Date of deliv	very Day Year
- -	the de	ysic	1 □Yes 2 □No 9 □ Unknown	4 ☐ Pregnant at ti 9 ☐ Unknown	ime of death	5 ☐ Other (specify)				Month	buy rour
ν, Τ	Physician: The law requires that the de this certificate has been signed by the al director, page 2 should be detached	by Pr	Part II. Other significant conditions	23e. Did tobacco use contribute to the cause of death?							
cords,	require been si nould b		7 107 malfile					1 🗆	Yes 2□]No 3☐ Prol	bably 4 Unknown
Z Z	ne law e has b ge 2 sł	Completed						24a. Was auto		24b. Were auto prior to co death?	opsy findings available ompletion of cause of
VII	ian; Ti rtificate tor, pa	a	25. Was case referred to medical		->0-0	27-5	26. Place of Dea	1 Yes	2 🗆 No	1 □ Yes	2.1No
> 1	hysic this ce al direc	To B	examiner? 1 Yes 2 No			tpatient 3 □ DOA C	other: 4 \sum Nursing H	lome 5 Resi	idence 6		ify)
	ding F	tion:	27. Manner of Death Natural 5 Pending Accident investigation	28a. Date of Injury (Month, Day,	Year) 28b. T	njury W	juryat ork? □Yes 2□No	28d. Describe	how injury	occurred	
VISION OF	r Atten er deal rector. by the	ertification:	3 Suicide 6 Could not b	e 290 Place of Injun	/ - At home, far (Specify)	m, street, factory, office		28f. Location (City or To	Street and	Number or Run	al Route Number,
5	oital or urs aft eral Dii	O		lu							
	To the Hospital or Attending Physician: The i within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier Certifying Pl (Check only one) 2 Medical Example (Check only one)	nysician: To the best of miner: On the basis of e and manner state	examination and	, death occurred at the d/or investigation, in m	time, date and place y opinion, death occi	e, and due to the urred at the time,	cause(s) , date and	and manner as a place, and due t	stated, to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifler	PAIUS		29c. Lice	nse number		29d. Date	e signed (Month,	Day, Year)
	22	J	AMA	1 200			21438		ING	416	2009
	(D)	7	30 Name and address of erson who	complete use of dea	th (Item 23a) (Type, Print)	MEK	GHUPY	Mo	(PPPV)	MOLIYE/
	Sta		31. Date filed (Month, Day, Year)	32. Registrar	s Signature	pare			-		
	Registra	वा	MAY 18 20	109 Brown	1 10. 1	7					

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 29d per phys. G892 6/10/09 dk
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 30 M 2009 Matlick, Jr. 18, В. Dailev /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomico Salisburu ri Year | If Under 24 Hrs Salisburg Rehabilitation + Nursing Ctr.
5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Funeral Days Months Hours Min 1 X M 2 □ F 4-30-1938 Pennsylvania 210-28-5828 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Extractional Exercitied at once. 1 □Yes 2X No Director Mardela Springs MD Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21837 8130 Baptist Church Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 195
If Yes, Give Year or Dates: 195 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 1956-Dailey Mattic 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 🛛 No Specify. ģ 3 ₩ Widowed 4 □ Divorced 1957 Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chemical Company Chemical Operator 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Matlick, Sr. ပ္ В. Julia Dailey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Salisbury, Maryland 21801 Jeffery Matlick - Son 233 Naylor Mill Road, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Delmar, Delaware Crematory of Delmarva 5-20-2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Juperal Service Licensee E. Main Street, Salisbury, Maryland 21804 23a. Par1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician eretroza ear disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ence of): Examiner Hospital or Attending Physlcian: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 1 → 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No 1 □Yes 2 LINO funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 10 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the dead of the cause of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. To the I 29d. Date signed (Month, Day, Year)

May 19, 2009 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jilliam 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

		-	For State of Ma		artment of Heal <i>rtificate of Dea</i>			ene g. No. 2 A A Q	17061		
	_		1. Decedent's Name (First, Middle, Last)			2.	Date of Death		3. Time of Death		
	Physicia /Medic		HILDA E. M	URRAY]	MAY	18 2009	8:39 A ^M		
	Examine		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loca	tion of Death	4c. County of Death				
1			ATLANTIC GENERAL HOSPITAL		BERLIN If Under 1 Year If U		. Date of Birth	WORCE	STER place (State or Foreign		
	Funeral		1□M oK E	(In yrs. last birthday)		urs Min.	/Month, Day, JNE 6,	Year) Cou	intry) RYLAND		
	Director	_ L	215-26-7368 Usual Residence of Decedent	78 Yrs.		μı	INE O	1930 FIA1	KILAND		
	/land	- 1	10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits		
	Mary a-f sh	ior	DELAWARE SUSSEX		1XIYes 2 □ No						
	or 28	Director	10e. Street and Number	g. Citizen of What Cou	intry?						
	23a	la l	22 LIGHTHOUSE ROAD		19975 Was Decedent of Hispani If Yes, specify Cuban, Me			USA	i la dia a		
336	ges 1 and 2 should be filed within 72 hours after death with the Maryland t of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be neithed at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent 1 Armed Forcas; 2 □ 1 Yes 2 □ 1 Yes Give Year or Dates:	14. Race - Amer Black, White Specify: WH	ican Indian, , etc.						
21215-0036	"nature	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	edent's Usual Occupation e kind of work done during DO NOT use retired)	6b. Kind of Business/li	ndustry				
12	filed within Hygiene. other than "	dmo	Elementary/Secondary (0-12) College (1-4or 5		BUILDING S	SUPPLY					
	i Hyg other ent, I	Be	17. Father's Name (First, Middle, Last)		18. 1	Mother's Name (/	First, Middle, M	laiden Surname)	iden Surname)		
'lan	should be and Mental s marked c umatic eve	고 B	SPENCE ELLIOTT		E	HAZEL	PAF	RSONS			
Maryland	2 shou and N is ma		19a. Informant's Name/Relationship (Type. Print)		ing Address (Street and N			•			
	1 and 2 Health a tem 27 is	Н	DIANNE MAGEE/DAUGHTER		7 LIGHTHOUSI osition (Name of ematory or other place)	E ROAD,		LLE, DE. 1			
altimore,	Pag ant:		20a. Method of Disposition 1 △ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	SELBYVILLE, DE.							
Balt	permit. Departr Importa any Inj		21. Sign fure Fundral Service Licensee	H	2. Name and Address of ASTINGS FUNI	ERAL HOM			. 19975 Approximate Interval Between		
70D 0839 8760,	Physician / Medical Examiner as the burial-transit as the burial-transit	edical Examiner	23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
/4/1930 //8/2009 O. Box 6	ath certi attending or use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 Yes 2 TNo 9 Unknown Unknown Unknown 23c. If yes, outcome 1 Live birth 4 Pregnant 9 Unknown Unknown 12c. 1			23d. Date of del Month	ivery Day Year				
ords, F	quires that the de n signed by the a lid be detached t	þ	Part II. Other significant conditions contributing to death to the significant conditions contributing to death to the significant conditions contributing to death to the significant conditions contributing to death to the significant conditions contributing to death to the significant conditions contributing to death to the significant conditions contributing to death to the significant conditions contributing to death to the significant conditions contributing to death to the significant conditions contributing to death to the significant conditions contributing to death to the significant conditions contributing to death to the significant conditions contributing to death to the significant conditions contributing to death to the significant conditions contributing to death to the significant conditions contributing to the significant conditions contributing to the significant conditions condition	Part I.		oacco use contribute to es 2 ☐ No 3 ☐ Pr					
, o	The law ate has b	Completed	31 pacemak	l perforr	autopsy prior to completion of cause of death?						
marray	clan: ertific ctor,	Be (25. Was case referred to medical examiner?			Place of Death	(Check only on	e)			
\$ 5	Physician: r this certific ral director, I	인	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpati	ent 2 ER/Outpati				ence 6 Other (Spe	cify)		
S n	ng ifte		27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 1 Natural 5 Pending investigation M 1 Yes 2 No								
Hilde (Division	or Attending after death. Director: After in by the funer	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of In building, e		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
I	To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu	Medical Ce	29a. Certifier (Check only one) Certifying Physician: To the best cone) The dical Examiner: On the basis and manner s	of examination and/or	ath occurred at the time, c investigation, in my opinio	date and place, a on, death occurre	nd due to the d d at the time, d	cause(s) and manner a late and place, and due	s stated. e to the cause(s)		
	To the within 2 To the comple	Me	29b. Signature and title of certifier	ala	29c. License nui	mber 5 5	5906	9d. Date signed Mont	sh, Day, Year)		
	49N		30. Name and address of person who completed cause of	EES ,31	Print) FRAN	IKLI	VA	WE BE	ERLINA		
	Sta Registr		31. Date filed (Month Day, Year) 32. Regist	rar's Signature	Janks)	•		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Month **Physician** 1:55 A M 2009 17 MCDONALD May MARY JANE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Frederick Frederick Frederick Memorial Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday) Min. Months Days Hours 1 □ M 2 🕱 F 81 219-20-4650 Aug. 26, 1927 Maryland Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10h. County 1 □Yes 2 XINo Director Middletown Maryland Frederick 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21769 United States 4241 Old National Pike Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2XX Married If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No Specify Specify: White Completed by 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Textile Workers Union Union Organizer 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice Burkett Raymond Buchanan ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4241 Old National Pike, Middletown, MD 21769 Marshall David McDonald/Husband 20b. Place of Disposition (Name of cematery, crematory or other place)
Resthaven
Memorial Gardens 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 Frederick, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature June Service Linesee 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence f): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 Yes 2 July 9 Unknown 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an DM autopsy performed 1 □Yes 2 □No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₩ 1 Deatient 2 ER/Outpatient 3 DOA

Examiner law requires that the death certificate be executed Box 68760, P.O. I Division of Vital Records, certificate has The

physician and s the burial-trans attending properties for use as ned by the a s been signed b page 2 Certification: To

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be reserved.

Physician

/Medical

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, p

12	

State Registrar

Medical

27. Manner of D ath

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

1 Natural

29b. Signature and title of certifier 20

28a. Date of Injury (Month, Day, Year)

and manner stated.

29c. License number

MDD 66166

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

400 West 7th Street, Frederick, MD 21701 Mudusar Raza, M.D.

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year) 2009

5 Pending

investigation

6 Could not be determined



State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** YAY 8 AGNES MARIE MURRAY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HIOSMIO 344/36/M REGIONAL MEDICAL TENINSULA If Under 1 Year | If Under 24 H 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 □**X** Days 09/09/40 MARYLAND 216-38-8046 69 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a State 28a-f show Department of Health and Mental Hygiens "Intuition series used in the way ya Inportant: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in including Examinating must be notified at once. 1 XYes 2 □ No Director WORCESTER POCOMOKE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21.851 402 BANK ST. death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 2 should be filed within 72 hours after on and Mental Hygiene.
Is marked other than "natural", or iter 1 ∏Yes 2 ∰No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 ☐ No Specify: 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) HATRDRESSER SELF 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **ANNIE GINN** TINKNOWN ပ 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 402 BANK ST. POCOMOKE, MD JAMILIAH MARSHALL, DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 Burial 2 Cremation 3 Removal from State POCOMOKE, MD SHILOH U.M. CEMETERY 05/23/09 4 Denation 5 □ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Lice see 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. COOPER & HUMBLES FUNERAL CO. ACCOMAC, VA 23301 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metastatic brest Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760. attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. After this certificate has been signed by the funeral director, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1K Yes 2 □ No 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 Pending investigation 1 □Yes 2 □ No after death. 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within 24 29d. Date signed (Month, Day, Year) 29b. Signature and itle of certifie 29c. License number 1450497 5/18/09 eted cause of death (Item 23a) (Type, Print) 30. Name and address of person who compl 3049 100 E CALLOI BAQ Chris 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 2 0 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Las 1230 M NISAI. **Physician** UDAE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Annapolis Anne Arundel Medical Center Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Jan. 29, 1938 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours 1 □ M 2 🗷 F Maryland Director 216-36-5799 Usual Residence of Decedent 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Modical Exeminar must be notified at 1X Yes 2 □ No Director Prince George's Bowie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20715 2507 Kevin Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status White 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1∐Yes 2∐No Specify: þ **3** Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Graphic Artist Graphics 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic months. 17. Father's Name (First, Middle, Last) Be Helen Beatrice Sakers William Paul Singer ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20715 Bowie, MD 2507 Kevin Lane Julia K. Misal / daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 5/20/2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park Cem. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee, Beall Funeral Home Bowie, MD 6512 NW Crain Hwy. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-trans Due to (or as a consequence of) Box 68760, eath certificate be Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Ectopic pregnancy Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown P.0 ů, 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. icate has been signed page 2 should be det Division of Vital Records, ≥ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐Yes 2 ☐No 1 ☐ Yes 2 🗆 No or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After t 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number D 21438 May 15, 2009 DEFENSE HIGHWAY ANNAPOUS M DRIYO 29b. Signature and title of cartifier Name and address of person who complete cause of death (Item 23a) (Type, Print) 11CHME

State Registrar

31. Date filed (Month, Day, Year) MAY 18 2009

62. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** P^{M} 2009 6:30 17 Suheil Elias Mansour May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Apt.#13 Montgomery Derwood 16117 Crabbs Branch Way 8. Date of Birth
(Month, Day, Year)
July 5, 1955 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Israel 1 X M 2 □ F 53 212-66-9742 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Machinal Examinar must be notified at 1 ☐ Yes 2X No Derwood Director MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20855 United States 16117 Crabbs Branch Way Apt.#13 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural", or iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1∐Yes 2XINo White Specify: ≥ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (2-4or 5+) Restaurant Chef 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sarah Gannon Elias Mansour 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m any Injury or other traum once. 16117 Crabbs Branch Way Apt#13 Derwood, MD 20855 Ana Maria Mansour (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition May 22, 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, MD Gate of Heaven Cem. 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home Ciutis 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Minutes Physician Sudden Cardiac Death disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 20 Months Congestive Heart Failure Sequentially list conditions, Due to (or as a nonsequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the hurst-transit 10 Months Cardiomyopathy Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 10 Years Coronary Artery Disease IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) 1 □ Yes 2 □ No. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Hypothyroidism, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Diabetes autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 👿 Residence 6 ☐ Other (Specify) 1X Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 1 🖸 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cer May 18, 2009 D65447 n who completed cause of death (Item 23a) (Type, Print) 15225 Shady Grove Road, Rockville, Maryland 20850 M.D., Sean Charles Beinart, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 20 Registrar

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 9:00 A M 5 eWiomb 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bultmore Med Ral Cente 47 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, ec. 2, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Min. 1 € M 2 □ F Months Days 55 264-08-1300 Dec. Massachusetts Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1X Yes 2 □ No Director Frederick Maryland| Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 405 Lee Place 21702 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify Specify: White þ 3 ☐ Widowed 4 🔯 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) HVAC Technician Heating / Cooling 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harold Newcomb Mary Florence Bezzetti ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Best Fr<u>iend</u> 101 Edinburgh Way, Walkersville, MD 21793 Mary Ellen Newcomb 20b. Place of Disposition (Name of cemetery, crematory or other place)
Restnaven 20c. Location - City or Town, State 20a. Method of Disposition 27. May 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Memorial Gardens Resthaven Funeral Services, Skkot Cody P.A. 21. Signature of uneral Service Licensee 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 Approximate Interval Between Onset and Death 23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final e or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. **Physician** -ungemia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 000 1 ☐Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: / 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours aft le Funeral Di letely filled ir 29a. Certifier TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) within 2 To the F and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 04 Name and address of person who completed cause of death (Item 23a) (Type, Print) Gran 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

DHMH 17 Rev 1/2001

			1. Decedent's Name	e (First, Middle, Last,)				_			2. Date of De			/o.o.v	3. Time	of Death
	Physici		Margaret	Aleene	Newcomb					Month May	^{3y} 2009	'ear	1:37 PM				
-	/Medic Examin	4a. Facility Name (4b. City,	4b. City, Town, or Location of Death					4c. County of Death								
والمسا	LXdiiii	CI	199 Roll	ins Avenue	e #815	Roc	kvil	le			Me	Montgomery					
	Funeral		5. Social Security N			(In yrs. la	ast birthday	/) If Under			er 24 Hrs.	8. Date of Bir	th Vear	.)	9. Birthp	lace (State	e or Foreign
	Director 527–24–3256 1 M 2 XF 95 Yrs.									Hours	Min.	(Month, Da Apr 24,	19	14 F	Coui ans	as	
	ъ		Usual Residence of Decedent														
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	deat ms	Funeral	11. Marital Status		12. Was Decedent E Armed Forces?	ver in U.S	6. 13	. Was Dece	dent of F	lispanic C	Origin? (Sp	ecify Yes or No Rican, etc.))-	14. Race - American Indian, Black, White, etc.			
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21215-0036	les 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event; the Medical Examinar is used by rediffied at	Completed	Elementary/Seco	ondary (0-12)	College (1-4or 5-	+)		DO NOT u	ise retire	d)							
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Baltimore,	permit. Pages 1 Department of F Important: if ite any injury or ot		21. Signature of Fu	uneral Service Licens	ee/ 0/1		G	Silly 1	Abhle	*CFer	tatio	n Servi	ce	P.O.	Box	784	
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	/Medical		resulting in death)		Due to (or as a			<u>u</u>								1	_
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99	ath certificate be executed attending physician and or use as the burial-transit	an/Medical	IF FEMALE:												-		
Вох	eath certific attending p for use as	l/ue	23b. Was deceden	it pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectonic	pregnan	cv				23d. Date		,	Vees
_	dea ne att	sici	in the past 12 1 ☐ Yes 2	Ĭ X No	4 ☐ Pregnant at 9 ☐ Unknown			Other (s		-7				Mon	in	Day	Year
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Records,	w require been si should b	ba										1 🗆	Yes	2 🔼 No 3	B□ Pro	bably 4[Unknown
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<u>o</u>	ath. r: Aff	atio	1 X Natural 2 Accident	5 ☐ Pending investigation	(World, Da)	, rear)	injury	М		Yes 2	□No						
Division	Atte	ific	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of Inju	ry - At ho	me, farm, s	street, factor	y, office			28f. Location (City or To			r or Rur	al Route N	lumber,
Ö	al or afte I Dir	Certification:	4 🗆 Hollicae		building, etc	. (Opecity	′′					City of 10	wii, Ola	16)			
	spita hours inera y fille		29a. Certifier	1 Certifying Phy	sician: To the best	of my know	wledge, de	ath occurre	d at the t	ime, date	and place	, and due to the	cause	(s) and mar	ner as	stated.	- (-)
	ne Ho ne Fu le Fu	Medical	(Check only one)	2∐ Medicai Exam	Iner: On the basis of and manner sta		tion and/or	investigatio	n, in my	opinion, d	leath occu	rred at the time	, date a	nd place, ai	nd due	o the caus	se(s)
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral	M	29b. Signature and	title of certifier				29	c. Licen:	se numbe	r		29d. [ate signed	(Month	Day, Year	7)
]	Frank	Le Mint	wheel &	11)		D197	85			Mav	20,	2009)	
9			30. Name and add	ress of person who c	ompleted cause of de	eath (Item	23a) (Typ						1	,			
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State of Maryland / Department of Health and Mental Hygiene 2009

Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) May 31, 6:00 AM M 2009 Physician Kevin Scott Pyles /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick 809 A Motter Avenue Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Days Hours 17☑M 2□F 215-06-2684 1975 33 19, Maryland Nov. Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 □ No Director Frederick Frederick Maryland 10e. Street and Number 10g. Citizen of What Country? 21701 U.S.A. 809 A Motter Avenue Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) N/A None marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be fill Health and Mental H tem 27 is marked ott Teresa A. Zeigler Charles Ronald Pyles 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 5902 Meadow Road, Frederick, MD Mrs. teresa A. Pyles, mother permit. Pages 1 and Department of Health Important: If item 27 any injury or other to once. Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Gremation 3 Removal from State Mount Olivet Cemetery June 2, 2009 Frederick, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Leensee 22. Name and Address of Facility Keeney and Basford PA Funeral Home M00255 106 East Church St., Frederick, MD 21701 Approximate Interval Between Onset and Death tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one NEUMON11 Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit and Due to (or as a consequence of): physician Physician/Medical the. attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) the 9 Unknown 2 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Delay Developmental 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page performed? 1 ☐ Yes 2 🖸 No certificate 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Box 68760. Division of Vital Records, Hospital or Attending within 24 hours after death.

To the Funeral Director A completely filled in by the fu

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Umbedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

29b. Signature and title of certifier

29c. License number Ba035152 29d. Date signed (Month, Day, Year) June 1, 2009

30. Name an ddress of person who completed cause of death (Item 23a) (Type, Print) MO 80 Krana

Johnson Priva Frederick MO

State Registrar

Medical

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2009 Gill Physician a M Q 6 POST ETHEL ANN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGES DOCTORS COMMUNITY HOSPITAL LANHAM Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 ☐ M 2 □XF Yrs. MARCH 4, 1919 MARYLAND 90 Director 577-14-5818 Usual Residence of Decedent 10d. Inside City Limits 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a. State ? Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Experiment must be notified at 1XYes 2 □ No Director COLLEGE PARK PRINCE GEORGES 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20740 9026 49th AVE. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛱 No Specify: þ WHITE 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) TELEPHONE CO CLERK 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental F Be be f FORR JULIANNA BISHOP ROMAN ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health at Important: If item 27 is any injury or other trau 10100 DUBARRY ST., GLENN DALE, MD.20769 BELCHER/GREAT NIECE JULIE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5-18-2009 RIVERDALE, MD. 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 22. Name and Address of Facili 21. Signature of Funeral Service Ligensee 22. Name and Address of Pacinity
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A.
5801 CIEVELAND AVE... RIVERDALE, MD. 20737 RIVERDALE, MD. M00091 5801 CLEVELAND AVE., 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS Hours **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hours TOXIC MEGACOLON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) requires that the death certificate be executed Exami physician and s the burial-trans COLITIS Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the attending phone IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. <u>Ş</u> 1 □ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □Yes 2 □ No 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this . Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death After t 1 Natural 5 Pending investigation 1 □Yes 2 □ No al or Attendi s after death. 2 Accident completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only

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> State Registrar

31. Date filed (Month, Day, Year.

29b. Signature and title of certific

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and manner stated.

of person who completed cause of death (Item 23a) (Type, Print)

Greenway Ctr Dr. Greenbelt, MD 20770 7500

29c. License number

022780

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar AMEND#23bperMD6/1/09, BMW, M, occ Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Rockville Hebrew Home of Greater Wash. If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Feb. 7, 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Hours Months 1 XM 2 □ F 1954 Maryland 55 214-60-5798 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If "Medical Examinations and injury or other traumatic event, If "Medical Examinations and injury or other traumatic event, If "Medical Examinations and injury or other traumatic event, If "Medical Examinations are also and a second and a second and a second and a second and a second and a second and a second and a second a second a second and a second a ¥ Yes 2 No MD Montgomery Gaithersburg Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20877 U.S.A. 7649 Laytonia Drive Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∏Yes 2 **X**No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 XNo Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) National Institute Elementary/Secondary (0-12) College (1-4or 5+) Caretaker of Health 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Juanita Doris Byrd Kenneth Atwell Payne Sr ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7649 Laytonia Dr Gaithersburg, MD 20877 Hazel Thomas- Friend Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State 5/20/09 Hanover, MD Ardent Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Snowden Funeral Home, PA 21. Signature of Funeral Service Consee 246 N. Washington St Rockville, MD20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner, stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year)
MAY 16, 2009 29b. Signature and title of certified 30. Name and address of person who completed cause WTRUSTED DUCKVILLE, MOZOPS

State Registrar

DHMH 17 Rev 1/2001

Year)

)9-03845 Adrian K. Rogers		Please Type of amend #15 Slate	or Printin Black In BoétMain∏la6893De7obl	delible 29/09	ink. Ensure of#Health and	All Copie Mental H	es Are Legi ygiene	ible.	00 1707
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Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. The I To the Funeral Director: After this certificate i completely filled in by the funeral director, page	ledical C	29a. Certifier 1 Certifying Physical Check only 2 Medical Examination	sician: To the best of my knowle ner:On the basis of examination and manner stated.	edge, death and/or inve	occurred at the time, stigation, in my opini	date and place, a on, death occurre	and due to the cau ed at the time, date	use(s) and manner as e and place, and due	to the cause(s)
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		30. Name and address of person wi Patricia Aronica-Pollak I	MD. Assistant Medica	I Examin		Street, Baltin	nore, MD 2120	01	
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			State of Maryland / [rtment of H tificate of D			ene g. No. 2009	17972
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#	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	,	4c. County of Deat	h
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Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modeal Experiment sate or till of any Injury or other traumatic event, the Modeal Experiment.				g Address <i>(Street a</i> Vyngate D			City or Town, State, .	Zip Code)
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	execur and al-trar	Examiner	that initiated events c. Due to (or as a consequence	of):					
8760	ficate be executed physician and sthe burial-transit	dical E	d						
9	tificat ig phy as the	ledic							
ROX	eath certific attending p for use as	N/us	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deatl	h 3[Ectopic pregnancy	,		23d. Date of de	
O. E	ed for	Physician/Me	1 Yes 2 No 4 Pregnant at time of death		Other (specify)			Month	Day Year
σ.	at the de d by the a etached	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting it	in the un	dadvina couco divo	on in Port I	23e Did tob	pacco use contribute t	the cause of death?
Vital Records,	ires that signed I d be det	þ	artin. Other significant containers contributing to death but not resulting to	iii die dii	denying cause give	in in the case is	1 □ Ye		robably 4 🗆 Unknown
Š	w requir s been s should	Completed					24a. Was ai	24h Mara a	utopsy findings available
Ř	he lav e has ge 2 a	du					autops perforn	y prior to death?	completion of cause of
ē	in: Ti tificate or, pa		25. Was case referred to medical			26 Place of Dear	1 ☐ Yes 2 th (Check only on	4	s 2 No
	ysicla is ceri	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/O	outpatien	t 3 DOA Othe			ence 6 □Other (Sp	ecify)
<u></u>	ding Physiclan: The law h. After this certificate has funeral director, page 2 s	T:U	27. Manny of Death 28a. Date of Injury 28b.	Time of Injury	28c. Injury Work			ow injury occurred	
<u> </u>	Attendir death. ctor: Af y the fur	atic	2 Accident investigation	,,		Yes 2□No			
Division of	I or Atteno after death Director:	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, for building, etc. (Specify)	arm, stre	eet, factory, office		28f. Location (St City or Town	reet and Number or F n, State)	ural Route Number,
	pital o		200 Cartifier 1 Description Physician To the heat of mulesquied	an dooth	and urrad at the tim	no, data and place	and due to the c	ausa(s) and manner	ac etatad
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certiffer 1 ☐ Certifying Physician: To the best of my knowledg (Check only one) 1 ☐ Medical Examiner: On the basis of examination a and manner stated.						
	To the Hos within 24 h To the Fun completely	Me	29b. Signature and title of certifier		29c. License	e number	2	9d. Date signed (Mor	th, Day, Year)
	-		1000		D6.	0417	3	5-18-2	009
	6		30. Name and address of person who completed cause of death (Item 23a)) (Type, I	Print)				21702
KE			(Check only one) 2 Medical Examiner: On the basis of examination a and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) Hence in Shah 31. Date filed (Month, Day, Year) 32 Registrar's Signature	hon	nas To	hnson	Dr. F	redevice	MB
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	ha	del				
	negisti	ш	TITLE DE LOUD CETSON DE	14 68	Phones.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G892 6/10/09 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 5 Month 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1^D3 **Physician** 2009 6:30P M John Henry Routzahn III /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick 6911 Picnic Woods Rd. Middletown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Days Months Hours Min. **1**√2 M 2 □ F 64 12/8/1944 MD Director Usual Residence of Decadent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar mine. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No MD Frederick Middletown Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21769 USA 6911 Picnic Woods Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1968 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2**X** No Specify. Specify: White þ 3 Widowed 4 XDivorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) farming farmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dorothy Holmes John H. Routzahn Jr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Brown (Friend) 6911 Picnic Woods Rd., Middletown, MD 21769 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial □ Cremation 3 Removal from State Lutheran cemetery 5/18/2009Middletown, MD 4 Domation 5 Dther S ature of Donald B. Thompson Funeral Home POB 18, Middletown, MD 21769 omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, live one lause areach line. Part1. Enter shock, or he rt failure. List only one Im Plate Cause Cinal di ease Condition resulting in de Imp henispheric cra **Physician** Mrsine /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus (Useas of July) that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Ospiration and burial-trai Division or Vital Records, P.O. Box 68760, physician Physician/Medical as attending | 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 Tyes peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 1 Yes 2 No certificate Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \subseteq Nursing Home 5 Residence 6 \subseteq Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of pry knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 00037178 5/15/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 KB Brunswick 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 19 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** USSOLL /Medical 4a. Facility Name (If not institution, give street and number) Examiner OMERFOR If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🔀 F 217-44-0413 104 Director May 6, 1905 New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at Maryland Montgomery Silver Spring 1 ☐ Yes 200 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 Sunnyside Drive 20910 U.S.A. Funeral within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Married 2 Married 2 Married Maryland 21215-0036 1 ☐ Yes 🏖 No Specify: White þ 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the M Entomologist Federal Government 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carlton Russell Lillian Averil 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Barnes/great-niece 33 Southgate Avenue Annapolis, Maryland 21401 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Eremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/19/2009 Baltimore Crematory Baltimore, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Fineral 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last aftending physician and for use as the burial-transit certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 mg Month Year 5 Other (specify) signed by the a d be detached for P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by PIBRILLATION 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2□No 24a. Was an page 2 s autopsy performe certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2**□** No 2 ER/Outpatient 3 DOA 2 1 Inpatient To the Funeral Director: After this completely filled in by the funeral dir 27. Mann Toeath 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division or Attending (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide after To the Hospital within 24 hours 1 🗂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number

State

State Registrar

DHMH 17 Rev 1/2001

MAY 19 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** RYLIE RAY 18, 2009 5:40 A MAY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY Hebrew Home of Washington Rockville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 060-22-0847 New York Director 79 Jan.18,1930 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 XYes 2 No Director MD Montgomery Germantown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20874 U.S.A. 18434 Stone Hollow Drive Funeral death 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 XYes 2 ☐ No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Black þ 48-51 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Electronic Engineer TEXACO 2 vrs traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be John Wright Moretta Ray ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if item 27 I 18434 Stone Hollow Dr, Germantown, MD 20874 permit. Pages 1 and 3 Department of Health Important: If Item 27 any injury or other tn once. Sarah Ray (Wife) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify) Ardent Crematory 5/19/09 Hanover, MD ago ture of Fun I Se vice I cense 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850 23a. Part1. Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** DEPSIS /Medical Due to (or a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of) Division or Vital Records, P.O, Box 68760. Physician/Medical the attending p 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 2 Hospital: 2) No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Attending 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ō 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

in 24 hours after death.

the Funeral Director: After this certific in pletely filled in by the funeral director, To the Hospital o within 24 hours aft To the Funeral Di completely filled in

> State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 32 Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D35/68

FINDA A. BENSON, M.D.

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month 2009 MAY Norman G. Sullivan /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner SAUISBUR Medi NSAVA HICOMICO RPLIUNAL MIDROL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 1 **X**M 2 □ F Davs **Director** 217-16-9510 August 13, 1923 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show other than "natural", or items 23a or 28a-f sheat, the Medical Examinar must be notified 1 TYes 2 □ No Director DE Sussex Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 608 Delaware Avenue 19940 U.S.A. by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1⊠Yes 2 No 1943− If Yes, Give Year or Dates: 1945 1 Never Married 2 X Married Itimore, Maryland 21215-0036 1 □Yes 2 🛣 No Specify: 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Carpenter Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental Ernest Sullivan Katie Baker ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) f Health (Wife) 608 Delaware Avenue Emily Jane Sullivan Delmar, DE 19940 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ites any Injury or ott once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Stephens Cemetery May 21, 2009 Delmar, Delaware 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility
Short Funeral Home East Grove Street Delmar, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** pronary orley /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Box 68760. signed by the attending physiclan I be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 - Ectopic pregnancy Day Month Year 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 **X** No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death Natural Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) F. HUBER, MO 00067577 083040

Registrar

DHMH 17 Rev 1/2001

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State

Horian Hube 31. Date filed (Month, Day, Year) 100 & CAPROLL ST

Salisbury, mo

30. Name and address or person who completed cause of death (Item 23a) (Type, Print)

MAY 20 2009

32 Registrar's Signatur

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			For State Registrar	State of	Marylan	•	artment of F rtificate of		and Mental H	ygiene Reg. No 2 0 0	9 17977
	Physici	an	1. Decedent's Name (First, Middle,	,	D. I. D. D. C.				2. Date of D Month	eath Day Ye	3. Time of Death
4	/Medic	cal	DALLAS 4a. Facility Name (If not institution,		PARPAG	LIONE	4b. City, Town, o	r Location o	May f Death	20 200 4c. County of	
Ч	⊏xamır	ier	BERLIN NURSING		,	N CTR.	BERL			,	ESTER
	Funeral Director		222-22-9457	. Sex 1 M 2 □ F	. Age (In yrs.	last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. (Month, L	irth 99. (14, 1938)	Birthplace (State or Foreign Country) DELAWARE
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	the Marylan 28a-f show	ctor	DELAWARE SUSSE	X	F	RANKFO	RD				1 □Yes 2X No
	vith the	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wha	at Country?
	ns 23s	Funeral	34933 ROXANA RO	12. Was Deced	ent Ever in U.	S. 13. 1	19945 Was Decedent of H		ain? (Specify Yes or N	USA 	American Indian,
ე 36	2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Midical Evan, in a first by multing at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Force	es? No		fYes, specify Cuba 1 □Yes 2 X No	an, Mexican, Specify:	gin? (Specify Yes or N , Puerto Rican, etc.)	Black, \ Specify:	WHITE
13°	72 hours "natural", dical Exa	eted	15. Decedent's (Specify only highest	Education grade completed)		(Give	dent's Usual Occup	durina most	of working	16b. Kind of Busin	ess/Industry
Sparpaglione Palla036	within iene. than	Completed	Elementary/Secondary (0-12)	College (1-4	lor 5+)		STRUCTIO	- /	KER	CONSTRU	CTION
ed I	s 1 and 2 should be filed wit f Health and Mental Hygien Item 27 Is marked other that other traumatic event, Inc	BeC	17. Father's Name (First, Middle, La	est)				18. Mother	r's Name (First, Middl	e, Maiden Surname)	
yla	s f and 2 should be in Health and Mental item 27 is marked oother traumatic ever	은		SPARPAGLI	ONE	T			GARET	DONOVAN	
Mai	nd 2 sh ulth and 27 Is n r traun		JOHN E. SPARPAGL		HER		-			ber, City or Town, Sta DELAWARE	
pa Fe,	of Hea		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of natory or other place	-	Date	20c. Location - Cit	
iar Imc	Pages tment of I tant: If ite jury or o		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	cify)	ate		EMETERY		/23/09	ROXANA,	DELAWARE
Ball	permit. Pages Department of Important: If it any Injury or once.		21. Signatury of Fundami Seprice Lic	censee Jan	1		Name and Addre			ELBYVILLE,	DE. 19975
			23a. Part 1. Enter the disease, or co shock, or heart failure. List or	mplications that cau ly one cause on eac	ised the death of line.	h. Do not ent	er the mode of dyir	ng, such as	cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	r as a consequ	uent of):	MENT	11-1	7		
1	Examiner		Sequentially list conditions	b	40 4 0011004	doi:12.01/.					
	ted sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or	r as a consequ	uence of):					
Ć,	execu in and ial-trar	Exan	that initiated events resulting in death) Last	c Due to (or	as a consequ	uence of):					
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_	certific Iding p	/Med	IF FEMALE:	23c. If yes, outco	me of pregna	incv		0.		20d Date a	A deline
P.O. Box	ding Physicism: The law requires that the death certif. Are this certificate has been signed by the attending funeral director, page 2 should be detached for use as	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live bir	th 2 ☐ Fetal nt at time of d	Ideath 3	Ectopic pregnand Other (specify) _	у		23d. Date of Month	
	s that gned by e deta	y Ph	Part II. Other significant conditions	s contributing to dea	th but not resu	λ		en in Part I.	23e. Did	tobacco use contribu	ite to the cause of death?
Division of Vital Records,	require een się lould b	ted t	END STAGE	LEN	AL)15E1	95E		1□]Yes 2 □ No 3[Probably 4 Unknown
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tal	sn: Th tificate or, pag	ပ္သ	25. Was case referred to medical					26 Place	1 ☐ Yes	2 □ /No 1 □	Yes 2 (2No
f Vi	nyslci nis cer I direct	To Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Ing	patient 2 🗌	ER/Outpatier	t 3 □ DOA Oth	or:		sidence 6 Other	(Specify)
o uc	IIng PI	ion:	27. Manuar of Death 1 ∠ Natural 5 ☐ Pending		Injury Day, Year)	28b. Time of Injury	Wor	k?		how injury occurred	
/isic	Attending r death. ector: After by the funer	ficat	2 Accident investigat 3 Suicide 6 Could not	ho	f Injury - At ho	ome, farm, str	eet, factory, office	Yes 2□N	28f. Location	(Street and Number	or Rural Route Number,
ρ	tal or	Certification: To	4 ☐ Homicide determine	building	, etc. (Specif	y)			City or To	own, State)	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 ✓ Certifying (Check only one) 2 ☐ Medical Ex	Physician: To the beaminer: On the bas and manne	is of examina	wledge, deati tion and/or in	n occurred at the ti vestigation, in my o	me, date and opinion, deat	d place, and due to the the control of the control	e cause(s) and mann e, date and place, and	er as stated. d due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier		-		29c. Licens	e number		29d. Date signed (/	Month, Day, Year)
	Acon		30 Name and address of	Mar	of dooth //r	000\ /T	D D	605/	2	2/20/6	74
•	. La.		30. Name and address of person when the state of the stat	YAFFA	6/L	1 23a) (Type,	EASTEN.	N	SHORE	DK, SA11	SBURY ND 21906
	Sta Registr		31. Date filed (Month, Day, Year)	2009 32 Reg	gistrar's Signa	ture.	arked			, - 1 - 1	

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 2009 5 18 17:21 Charles Aloysius Sutton /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico Peninsula Regional Medical Center Salisbury If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Months Days Hours Min. Yrs. Director 69 8-13-1939 New Jersey 155-28-3324 Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show and 2 should be filed within 72 hours after death with the Marylar leath and Mental Hygiene.

m 27 is marked other than "natural", or items 23a or 28a-f shov her traumatic event, its Medical Externing to a notified at 1 ☐ Yes 2 🔯 No Director MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 907 Outten Road 21804 Funeral USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Mental Health Therapist Mental Health of Health and Mental Hygitem 27 is marked other other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown Be 2 Charles Sutton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Sutton - Wife 907 Outten Road, Salisbury, Maryland 21804 Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Beth Israel Cemetery 5-21-2009 Salisbury, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bounds Funeral Home Signature of Funeral Service Licensee 705 E. Main Street, Salisbury, Maryland 21804 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List gruy one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARtery **Physician** pronsy /Medical Due to (or as a consequence of): Examiner 5CVI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of a Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, physician s the burial Physician/Medical attending for use as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Dubetes Melletres 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 254No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending Natural 2 Accident 5 Pending after death.

I Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled i To the Hospital TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation is provided in the cause of 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) miltord 106 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		П	1 - State of Maryland / Dep	rtificate of Death		g. No. 2009 17979
I	Physici		Decedent's Name (First, Middle, Last) KENDAL COLES STACKHOUSE		2. Date of Death Month MAY 15	3. Time of Death 09:47 P M
	/Medio Examir		4a. Facility Name (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER	4b. City, Town, or Location of D	Peath	4c. County of Death ANNE ARUNDEL
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 F 78 Yrs.	If Under 1 Year If Under 24		-
	yland how		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Li	ocation		10d. Inside City Limits
	e Mar Ba-f s	Director	MARYLAND ANNE ARUNDEL	ANNAPOLIS	3	1 ☐Yes 2 X No
	with th	Dire	10e. Street and Number	10f. Zip Code		g. Citizen of What Country?
	ms 23	Funeral	204 AUTUMN LEAF PLACE 11. Marrital Status 12. Was Decedent Ever in U.S. 13.	21401 Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P		UNITED STATES 14. Race - American Indian,
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Madicial Examinat must be natified at once.	þ	1 ☐ Never Married 2 M Married 3 ☐ Widowed 4 ☐ Divorced Armed Forces? 1	If Yes, specify Cuban, Mexican, P 1 ☐ Yes 2 X No <i>Specify:</i>	uerto Ricán, etc.)	Black, White, etc. Specify: WHITE
21215-0036	in 72 hou in "nature	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of DO NOT use retired)	working 1	6b. Kind of Business/Industry
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Maryland	be file ntal Hy od oth event	Be	17. Father's Name (First, Middle, Last)		Name (First, Middle, M	aiden Surname)
3	should Ind Men a marke	၉	ASA MATLACK STACKHOUSE		RYN COLLINS	
	and 2 sho eatth and n 27 is mi			ng Address (<i>Street and Number o</i> \\TTIJMN T.F.AF PT.A (IS, MARYLAND 21401
ore,	of Hea	1	20a. Method of Disposition 20b. Place of Disposition	sition (Name of		0c. Location - City or Town, State
Ĕ	Pages Iment of Italiant: If italiants or o		4 □ Donation 5 □ Other (Specify) CENTER	CE CREMATION MAY	18,2009 S	TEVENSVILLE, MARYLAND
Baltimore,	permit. Departr Imports any Inju		21. Signature of Funeral Service Licensee Will Express M00672	2. Name and Address of Facility I REMATION AND FUNDAD, ANNAPOLIS,	TELLOWS, HE VERAL CARE.	LFENBEIN AND NEWNAM P.A. 814 BESTGATE
	_		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			st, Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)			Onset and Death
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O. Box	requires that the death certif been signed by the attending hould be detached for use as	Physician/Me		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
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ğ	w requires to be signer as should be a	ed b	lung Cancer, Cardiomyesp	thy	1 □ Yes	s 2 No 3 Probably 4 Unknown
Records,	s t	Completed			24a. Was an autopsy perform	prior to completion of cause of
Vital	Physiclan: The la this certificate ha ral director, page 2	Bec	25. Was case referred to medical examiner?	26. Place of	1 ☐ Yes 2 Death (Check only one	
0	Physic this cral dire	မ	1 ☐ Yes 21 ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie			nce 6 Other (Specify)
\subseteq	ing or (fter	tion	27. Manner of Death Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day, Year) Injury 28b. Time of Injury	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe hov	v injury occurred
Division	A P 9 2	Certification:	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)		28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
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	To the Ho within 24 To the Fu completel	Medical	(Check only one) 2 Medical ExamIner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death	occurred at the time, da	te and place, and due to the cause(s)
h	§ 5 € €	1	29b. Signature and title of certifier		6	d. Date signed (Month, Day, Year)
	130	3	30. Name and address of person who completed cause of death (Item 23a) (Type, there is a superior of the super	Fold Solvmon	s Ishad Ro	9. Annapolis mo 2 1401
i	Sta Registra		31. Date filed (Month, Day, Year) MAY 1 9 2009 MAY 1 9 2009			,

1 - For State Registrar

	Physicia /Medic		1. Decedent's Name (First, Middle, Las	Suite				Month 05	Day 200	aar 0535 M
	Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or I		th	4c. County of Anne Ar	
,e ^{gi}	_	щ	Mandrin Hospice 5. Social Security Number 6		last hirthday)	If Under 1 Year	wood If Under 24 Hrs	8. Date of Bir	th 9	Birthplace (State or Foreign
	Funeral Director		219-05-0363		O Yrs.	Months Days	Hours Min		918	Country) MD
			Usual Residence of Decedent	•						And Inside City Limite
	arylar show	7	10a. State 10b. County		y, Town or Lo					10d. Inside City Limits 1 ☐ Yes 🛣 No
	the M	ecto	MD Anne Aru 10e. Street and Number	ndel Ed	gewate	10f. Zip Code			10g. Citizen of Wha	
	with a	Ö	1629 Cliff Drive				21037		US	•
	death	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.	S. 13. V	Vas Decedent of His f Yes, specify Cubar	spanic Origin? (Specify Yes or No	- 14. Race -	American Indian, White, etc.
٥	after or ite		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1		Tres, specify Cobar	Specify:	nto Fricari, etc.)	Specify:	White
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Ċ	in 72 n "nat	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	kind of work done do OO NOT use retired)	uring most of wo	orking	105. Killa 01 500.	ioos mass. y
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and	be file tral Hy d othe event,	Be (17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle	, Maiden Surname)	
ya Ya		٩	Leonard C. Phipps		T			C. Erbe		ata (7 in On da)
Za Za	d 2 sh th and 7 is n traun		19a. Informant's Name/Relationship (**) Pamela Capezio	Type. Print) Daughter		Cliff DR.			er, City or Town, St.	ate, Zip Code)
a,	s 1 and 2 should f Health and Mer tem 27 is marke other traumatic		20a. Method of Disposition	20b. F		sition (Name of natory or other place		Date	20c. Location - Ci	ty or Town, State
ê .	Pages nent of int: If it		th Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State			i	8/2000	Davideor	ville, MD
Baltimor	permit. Pa Departmer Important: any Injury once.		21. Signature of Funeral Service Licen	Lab	22	. Name and Addres	s of Facility Ha	rdesty F	uneral Ho	ome, P.A.
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XO RO RO	death certificate be executed eattending physician and dor use as the burial-transit	cian/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		Ectopic pregnancy			23d. Date	· ·
	e deal		in the past 12 months?	4 ☐ Pregnant at time of c		Other (specify)			Monti	n Day Year
7	ding Physician: The law requires that the d. h. After this certificate has been signed by the funeral director, page 2 should be detached	Phys	9 ☐ Unknown Part II. Other significent conditions of	ontributing to death but not res	ulting in the u	nderlying cause give	n in Part I.	23e. Did	tobacco use contrib	ute to the cause of death?
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NITAI N	clan: ertifica octor, p	ВеС	25. Was case referred to medical examiner?					eath (Check only		
5	Physician: r this certific ral director, i	မ	1 Yes 2 No 27. Manner of Death	Hospital:	ER/Outpatier		4 LI Nursing		idence 6. dether	Specify HOSpice
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DIVISION	Attending r death. ector: After by the funer	Certification:	3 Suicide 6 Could not be determined		ome, farm, str				Street and Number wn, State)	or Rural Route Number,
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	To the Hospital or Atten within 24 hours after death To the Funeral Director: completely filled in by the		(Check only 2 Medicel Exar	nysician; To the best of my kno niner: On the basis of examina						
:	ithin 2 o the	Medical	one) 29b. Signature and title of certifier (and manner stated.		29c. License	number		29d. Date signed (Month, Day, Year)
,	0 484		DANICULT	Hew	alun	D	2143	38	May	14,2009
	, [30. Name and address of person who	competed cause of death (Iter	n 23a) (Type,	Print) Dava	ac It	Sitlway	Auchan	15 MA Da ucab
4	rH		MICHHELJIL	LENUA MA	7, 40	FI DEFEN	75 11(2 Links	FINIALIOC	7 11 17 0140
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.2 0 0 9

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year Raymond Wallace Sherman 2009 May 15, 4:05 A^{M} /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1204 Grant Street Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | (Month, Day) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) 1K M 2 F 9/3/1926 Director 220-16-8009 82 Delaware Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the fivelical Examiner must be notified at Directo 1 XYes 2 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1204 Grant Street 21403 USA Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.

Int. If item 27 is marked other than "natural", or ite Black, White, etc. 1 Never Married 2 Married 1▼Yes 2□No WWII altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □ Yes 2 □ No Specify: Completed by White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Office Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leroy Stewart Sherman Mary Ethel Turner မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Rosalie Sherman - Wife</u> 1204 Grant Street, Annapolis, MD 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 □ Burial 2 □ Cremation 3 □ Removal from State Glen Haven Memorial Park 5/18/2009 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home, Inc 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) vostate concer **Physician** NEGVI /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of The law requires that the death certificate be executed Exam sician and burial-trans Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. 1 □ Yes 2 □ No investigation 24 hours after death Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 29b. Signature and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bestgate Rd. Annapolis, Md. 21401 valt selonich, mo 31. Date filed (Month, Day, Year) 32 Registrar's Signature

09-03946		Please Type or Print in Bla				gible.	
Steven Edward S		Ker State of Maryland /	•		ntal Hygiene	200	0 1708
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	Certificate or	T Death	2. Date of Deat	eg. No. 💪 🗓 U th	3. Time of Death
Medical Exami		Steven Edward Stocker			Month May 18, 2	Day Year 009	0830 hrs
		4a. Facility Name (if not institution, give street and number) 5225 Pooks Hill Road 1803		4b. City, Town, or Location Bethesda	n of Death	4c. County of Death Montgomery	
Funeral Director		5. Social Security Number 6. Sex 7. Age 1	(In yrs. last birthday)	Months Days Hou		th(MM/DD/YYYY) 9. Birt Foreig Cou	
è		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Locat	tion			10d. Inside City Limits
land f show any once		Maryland Montgomery	Bethesda				1 Yes 2 X No
Baltimore, MD 21215-0036 Permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other tranmatic event, the Medical Examiner must be notified at once.	Dire	10e. Street and Number 5225 Pooks Hill Road, #1803N		10f. Zip Code 20814		0g. Citizen of What Cour USA	·
eath with items 2	Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces?	If Y	as Decedent of Hispanic C Yes, specify Cuban, Mexic		- 14. Race - Ameri White, etc.	can Indian, Black,
after de al", or iner mu	y Fu	3 Widowed 4 Divorced If Yes, Give Year or Dates:		Yes 2 X No specia		Specify: Whit	e
2 hours "natur	Completed by	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12) College (1-4 or 5	during m	nt's Usual Occupation (Givnost of working life, DO NO		16b. Kind of Business/l	
036 vithin 7 ene. er than Medica	du	5+	Science	e Writer		Health Car	e Industry
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	Be	17. Father's Name (First, Middle, Last) Joseph Saul. Stocker		18.Moth	er's Name (First, Middle, I Ida Mae Meck		
MD 2. Id 2 should alth and M. In 27 is manuatic entermatic enter	ို	19a. Informant's Name/Relationship (Type, Print) Marc B. Stocker/Brother	3095	g Address (Street and N Piney Ridge Ro	ad, Evergreen,	CO 80439	
Baltimore, permit Pages I an Department of Hea Important: If iten		20a. Method of Disposition 1 Burial 2 XX remation 3 Removal from Sta	te crematory or ot	sition (Name of cemetery, ther place) an Crematory	May 19,	20c. Location - City or	
altim mit Pa partmen portant	}	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licenses	22.1	Name and Address of Fac	1009	Alexandria,	Virginia
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Physician /Medical / caminer		23a. Part I. Enter the disease, or emplications that caused failure. List only one cause each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a conse	n Wound	the mode of dying, such as	s cardiac or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and Death
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O. B.	된	Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause given in	Part I. 23e. Did to	obacco use contribute to	the cause of death?
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tal Records rian: The law requi certificate has been	Completed				24a. Was autop perfo	prior to death?	utopsy findings available completion of cause of
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Vita hysici this ce	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatie			Nursing Home 5	Residence 6 🗸 Othe	r: Scene
Division of Vital Records, To the Hospital or Attending Physician: The law requir within 24 hours after death. Yo the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should it		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Inju FOUND: May 18, 2009	FOUND:	Injury 28c. Injury at W	 Subject sho 	how injury occurred ot self	
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	Med	and manner stated. 29b. Signature and title of certifier		29c. License numb	er	29d. Date signed (Mo	nth, Day,Year)
15		(Antolina)		O.C.M.E.		May 19, 2009	
		30-Name and address of person who completed cause of d Laron Locke MD. Assistant Medical Exa		n Street, Baltimore,	MD 21201	<u> </u>	
St Regist	ate rar	_	r's Signature	RI			
	-	CIAL TO TOTAL					

			For State Registrar	State of M	arylar		artment of <i>rtificate o</i> i	Health and N f Death	/lental Hy	/gien Reg. No	7111	9	17983
	Physici	on	Decedent's Name (First, Middle	e, Last)					2. Date of De			'ear	3. Time of Death
	Physici /Medio		Henry H.	Scofield		r.	T		May	17,	2009		12:45 A M
	Examin	er	4a. Facility Name (If not institution	-				or Location of Death		40	County of		
	Funeral	7	Suburban Hospi 5. Social Security Number		je (In yrs.	last birthday)	If Under 1 Yea		8. Date of Bi	rth	Mont	_	ace (State or Foreign
	Director		326-20-3107	1 X M 2□ F	91	Yrs.	Months Days		(Month, D.) March		918	Couini [11 i 1	nois
_	and w		Usual Residence of Decedent 10a, State 10b, County		10c Cit	ty, Town or Lo	ocation					10	d. Inside City Limits
1	Maryla f sho	ţō	MD Montgo	mo#17			3041011						1¶∑Yes 2 No
	h the or 28a on Dotif	Director	10e. Street and Number	mery	FOL	omac	10f. Zip Code			10g. C	itizen of Wh	at Count	ry?
	th with	Ta D	10418 Demacrac	y Lane			20854	4		U.	S. A.		
	er dea items ier m	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - Black,	America White, e	
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I 700	illed w Hygie ther t	S	17. Father's Name (First, Middle,	12 (ast)		Denti	st of Ui	18. Mother's Name		-		y De	ntal Corps
SDG E	ld be i ental ked o ic eve	To Be	Henry Harland	· ·	r .				a McMul		i Surriame)		
2012	should and Mer s marke numatic	-	19a. Informant's Name/Relations	-		19b. Maili	ng Address (Stree	et and Number or Run			or Town, St	ate, Zip	Code)
± 25	and 2 ealth n 27 i		Kathleen Port	er / Daughte	er	817	Glyndon	St. SE, V	ienna.	VA	22180)	
17 d	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 ☐ Removal from State	20b. F	Place of Dieno	eition (Nama of	etery 5/22	Data	20c. L	ocation - Ci	ty or Tov	
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68760,	tificate be executed g physician and as the burial-transit	edical		d									
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О.	at the deal by the att tached for	ysician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 Pregnant at			Dectopic pregnar Other (specify)				Month	n I	Day Year
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	thin 24 the Formplete	Medical	29b. Signature and title of certifier	and manner sta	ited.	and/or in		opinion, death occurr	ed at the time,				
	ا گر		A CONTRACTOR OF	< 70			D do	6 & 1 6 0		230. D8	ite signed (ay, rear)
		-	30. Name and address of person v	who completed cause of de	eath (Item	23a) (Type.	Print)			-/			
			Kimberly Beth	Zuzak 8600	01d (George	town Rd.	Bethesda,	Maryl	and	2081	4	
	Stat Registra	_	31. Date filed (Month; Day, Year) MAY 20 2	009 Pen m	r's Signa	par	Red						

Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal-transit completely filled in by the funeral director, page 2 should be detached for use as the burnal-transit

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		Lorien of Mount				unt Ai			Carı		
ral			6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. last b		nths Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	y, Year)	Birthplace (State or Fo Country)	reign
tor		218-24-3022		79	113.			May 13,	1930	Maryland	
		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	vn or Location	1				10d. Inside City L	imits
5	Ŀ									1 □ Yes 2	
	Director	Maryland Frederi	.ck	Monrov							4
	Oire	10e. Street and Number			10	f. Zip Code			10g. Citizen	of What Country?	
		3867 Saint Clair	Court		2	1770		τ	JSA		
	Funeral	11. Marital Status	12. Was Dece Armed For	dent Ever in U.S.	13. Was [Decedent of H	lispanic Origin? (S an, Mexican, Puerl	pecify Yes or No-	. 14. F	Race - American Indian, Black, White, etc.	
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	þ	3 XWidowed 4 ☐ Divorced	If Yes, Giv Year or Da	e ates:	1 1	es ZIZINO	Specify:		Spe	White	
	Completed	15. Decedent's (Specify only highest	s Education	166	a. Decedent's	Usual Occup	ation during most of wor	rking	16b. Kind o	f Business/Industry	
	ple	Elementary/Secondary (0-12)	College (1	-4or 5+)	life. DO N	OT use retired	d)	Kiilg			
	P.O.	11		·	erator	•			Teleph	none Company	
	Be C	17. Father's Name (First, Middle, L	.ast)				18. Mother's Nar	ne (First, Middle,	Maiden Surr	name)	
	To B	Floyd Bascum Cr	eger				Marjorie	Ann Har	ner		
	-	19a. Informant's Name/Relationshi		ughtor 19	b. Mailing Ad					wn, State, Zip Code)	
		Barbara Jean Th		.	967 Cn	int C1	oir Cour	+ Monro	arria l	farming 2177	0
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	Physician/Medical	8	a. Hyp	27-19.01	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
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	iän	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bi	irth 2 ☐ Fetal deat ant at time of death		pic pregnancy er (specify)	/		23Q.	Date of delivery Month Day Yea	r
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2	Ю	OSTED MEDSIS	agitais	erker				perfo 1□ Yes	rmed?	death? 1 ☐ Yes 2 █ No	
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		27. Manner of Death	28a. Date o	of Injury 28b.	Time of	28c. Injur Wor		28d. Describe I			
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	erti	4 ☐ Homicide determin	buildir	ng, etc. (Specify)				City or Tox	vn, State)		
,								0.1.7 0.7 1.02			
	2	29a. Certifier 1 ₹ Certifying	Physician: To the	best of my knowledd	ge, death occ	urred at the ti	me, date and place	e, and due to the	cause(s) and	manner as stated.	
	dical C		xaminer: On the ba	best of my knowledgasis of examination a	ge, death occ and/or investig	urred at the til gation, in my o	me, date and place	e, and due to the	cause(s) and date and pla	I manner as stated. ce, and due to the cause(s)	
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		29b. Signature and title of certifier	who completed cause	e of death (Item 23a)	(Type, Print)	29c icens 29c Ave.	e number	e, and due to the urred at the time,	date and pla 29d. Date sig	ce, and due to the cause(s)	9
Sta	te	29b. Signature and title of certifier 29b. Signature and title of certifier 200 Person w 200 Person w	who completed cause	e of death (Item 23a)	(Typg, Print)	29c icens 29c Ave.	e number	e, and due to the urred at the time,	date and pla 29d. Date sig	ce, and due to the cause(s) gned (Month, Day, Year) 1 17 200	9

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-04264 State of Maryland / Department of Health and Mental Hygiene 2009 17985 Myron James Terpeluk Certificate of Death Reg. No. 1- For State 2. Date of Death Registrar 1. Decedent's Name (First, Middle,Last) Month Day May 28, 2009 1900 hrs Physician/ Examiner Myron James Terpeluk Me/ 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Fikton Union Hospital If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Foreign **Funeral** Hours Country) PA Months Days April 22,1932 77 Director 203-26-0850 1 X M 2 F Yrs 10d. Inside City Limits Usual Residence of Decedent 10c. City, Town or Location 10b. County 1 Yes 2 X X No Chesapeake City 28a-f show Cecil MD items 23a or 28a-f shoust be notified at once. 10g. Citizen of What Country? Director 10f. Zip Code 10e. Street and Number United States 21915 54 Chestnut Springs Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. White, etc. Funeral 11 Mantal Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death wil Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items: injury or other traumatic event, the Medical Examiner must be a injury or other traumatic event, the Medical Examiner must be a Armed Forces' 1 Never Married 1X Yes Specify: White Yes 2 XX No specify. If Yes, Give Year 1952-54 Divorced 3 X Widowed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done þ 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Auto Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturing Parts Worker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Plesak Dmytro Terpeluk Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 80 Chestnut Springs Rd., Chesapeake City, MD21915 James Wasylczuk/nephew 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Chesapeake City 1 X Burial 2 Cremation 3 Removal from State Maryland 06-03-2009 Rose of Lima Other Specify 4 Donation 5 21. Signature of Funeral Service Licensee 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. Chesapeake City, MD 318 George St.. Approximate Interval nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and vsician Death failure. List only one cause on each line Atherosclerotic cardiovascular disease ledical Immediate Cause (Final disease **=**xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed 23a,27,perME, g895 9/10/09 TT and Physician/Medical AMENDED tending physician a X UNPENDED 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year Day Month 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. Yes 2 ✔ No 3 Probably 4 Unknown þ 24b. Were autopsy findings available Completed 24a. Was an Records, prior to completion of cause of certificate has been ector, page 2 should autopsy death? performed? No 1 V Yes ✓ Yes 2 page 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical Division of Vital Other₄ Be Residence 6 Nursing Home 5 examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 this 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Dey,Yeer) After 27. Manner of Death 1 Yes 2 No 1 X Natural Pending Funeral Director: stely filled in by the 28f. Location (Street and Number or Rural Route Number, City Investigation 2 28e. Place of Injury - At home, farm, street, factory, office building, etc Accident Could not be 3 Suicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal To the and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie May 30, 2009 O.C.M.E. Monte 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Margarita Korell MD. 32 Registrar's Signature 31. Date file (MA) th (P2, Y2000) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 8:50 PM 2009 Osborne Lee Thompson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Washington Washington County Hospital Hagerstown
If Under 1 Year | If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2□ F Months Days Hours Director 218-24-8847 80 April 15 1929 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examinar must be molified at Director 1 ☐ Yes 2 X No Maryland Washington Hagerstown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 22013 Grove Road 21742 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 1 □Yes 2 🙀 No Specify: þ White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Manufacturing Estimator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Wilbur O. Thompson Ruth Head 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 is Shirley Thompson - Wife <u>22013 Grove Road, Hagerstown, Md. 21742</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any Injury or concept on XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/29/09 Rest Haven Cemetery Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CONCRY disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** chmoni Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of myocardial Exami 400 burial-t Due to (or as a consequence of): physician the burial P.O. Box 68760, chash. c The law requires that the death certificate be Physician/Medical as nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No ed by the detached i 9 Unknown 9 Unknown signed i I be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed: certificate 1 ☐ Yes 2 ☐ NO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 ☐ Yes 2 🛂 📉 б 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of ne Hospital or Attending P n 24 hours after death.

The Funeral Director: After t pletely filled in by the funera Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the within 2 29c. License number 9 0 29b. Signature and title of certifier 0060396

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M- SHED

32. Registrar's Signature

RIT

31. Date filed (Month.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death OLORES **Physician** 120 M 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** MANDRIN CHESAPEAKE HOSPICE HOUSE HARWOOD ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Min. 1 □ M 2 □ F Hours 212-34-9596 72 Director JANUARY 26, 1937 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Modeal Examinar invest be notified at 1 ☐ Yes 2 X No Director MARYLAND QUEEN ANNE'S CENTREVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 316 QUAIL RUN DRIVE 21617 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 ☐ Yes 2 **X**If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify. þ Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien Important: If item 27 is marked other than any injury or other traumatic event. 11 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM CRANE LUNA GREENE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN R. TOTH/HUSBAND 316 QUAIL RUN DRIVE, CENTREVILLE, MARYLAND 21617 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State WOODLAWN MEMORIAL PARK MAY 22,2009 EASTON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM CREMATION AND FUNERAL CARE, P.A., 814 BESTGATE ROAD, ANNAPOLIS, MARYLAND 21401 21. Signature of Funeral Service Licensee Will Eron M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final STROKE **Physician** years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 2 **Z**No the 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by -MEN TIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has certificate 2 No 2 🗆 No 1 ☐ Yes 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this funeral c 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred HOUSE 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

requires that the death certificate be executed Box 68760 o. ۵. of Vital Records, or Attending Physician: Division within 24 hours after death

To the Funeral Director: ,
completely filled in by the f Hospital

72 hours after

Maryland 21215-0036

Baltimore,

DHMH 17 Rev 1/2001

State Registrar

Medical

29a. Certifier

29b. Signature arid title of certifie

31. Date filed (Month, Day, Year)

AEZ

and manner stated.

· Lete NTA W

32. Registrar's Signature

Name and address of person who complete y use of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

DEFENSE / HGH WAY ANNAPOUS MOZIYO,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Joseph 6:42 p /Medical Francis May 17, 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 4403 Bywood Lane Montgomery Rethesda nder 1 Year I If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours **™** M 2 □ F 202-34-6137 Director 64 Nov. 8, 1944 Pennsylvania Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at Director 1 ☐ Yes 2 ☐ No Maryland Montgomery Bethesda 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4403 Bywood Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 201 Married 1 X Yes 2 ☐ No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1968–74 1 ☐ Yes 2 ☑ No Specify: Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 7 is marked other than traumatic event, if a lite Elementary/Secondary (0-12) College (1-4or 5+) 5+ Civil Rights Program Analyst US Dept. of Justice 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental Stephen George Talian Elizabeth Szecsody ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai once. Maria Esther Talian/Wife 4403 Bywood Lane, Bethesda, MD 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 😾 Burial 2 ☐ Cremation 3 ☐ Removal from State May 22, 4 Donation 5 Dother (Specify) All Souls Cemetery Germantown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20001 N0837 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Metastatic Non-Small Call Lung Cancer 36 mos. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician منتج اط for use as the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year Day 5 Other (specify) ed by the a o 1 Yes 2 No g 🗆 Unknown ۵. s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page perform 2 No 1 ☐ Yes 1 □ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{\text{\text{Nursing Home}}}\) 15 \(\text{\text{\text{Residence}}}\) Residence 6 \(\text{\text{\text{Other}}}\) Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 ☐ Pending investigation ours after death.

leral Director: A
filled in by the ft. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D33293 May 18, 2009 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Frederick Smith, MD 5454 Wisconsin Avenue, #1300, Chevy Chase, MD 20815 31. Date filed (Month, Day, Year, 32 Registrar's Signature State MAY 20 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Items 23a,24a,27 per dr., g892,06/10/09dhb
State of Maryland / Department of Health and Mental Hygiene

Amend Item 3 per me,g892,06/04/09dhb

Certificate of Death

Reg. No. 2 1 1 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Month **Physician** 4:23p John G. Vlavianos М May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1300 St. Pauls Way Crownsville Anne Arundel 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ☐ M 2 ☐ F Director 058-30-1593 75 10/10/1933 Greece Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location if than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 TXNo Director MD Anne Arundel Millersville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 478 Old Orchard Circle 21108 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced Baltimore, Maryland 21215-0036 White 1 □ Yes 2 No Specify: δ Specify: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. em 27 is marked other than ther traumatic event, Inc. In Federal Gov't Administrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Vlavianos Rudolph Maria George ၀ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 478 Old Orchard Circle Millersville,MD 21108 Lina Vlavianos Spouse item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If itel
any injury or ott 1 Burial 2 Cremation 3 Removal from State Our Lady of the Fields 5/26/09 Millersville,MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Timeral Service Line 15-22. Name and Address of Facility 851 Annapolis Road Gambrills, MD 21054 Hardesty Funeral Home P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Hypertension Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of). Hyperlipidemia The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): CERTIFICATI Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 **X**No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No 24a. Was an After this certificate has funeral director, page 2 s autops, performed: 2X No 1 □ Yes Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Other (Specify) BOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury 1 Natural Pending Investigation 1 ☐Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature ar 29c. License number 29d, Date signed (Month! Dav. Year) s of person who completed cause of death (Item 23a) (Type, Print) 30. Name and ad ZOOZMODICAL PARKWAY CIM STEB EVIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 04 Registrar

amend line 8 per fd aaco hlth dept 5/19/09 dlw
09-03866 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Frank Heywood Vitale 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day May 15, 2009 0720 hrs Frank Heywood Vitale **Medical Examiner** c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Upper Marlboro 13906 West End Farm Road If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Country)Maryland 10/28/1958 Months Min. Hours Days Director 216-74-8979 XM 50 Yrs 09/28/195 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any Yes 2 X No Maryland Prince George's Upper Marlboro 28a-f show If item 27 is marked other than "natural", or items 23a or 28a-f sho her traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20772 United States 13906 West End Farm Road 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 X Married Yes 2 X No Specify: White Yes 2 X No specify: Yes, Give Yea Widowed Divorced ⋧ 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 h Department of Health and Mental Hygiene. Self Employed Site Utility 1 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Hannah Ismer John Vitale 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13906 West End Farm Road, Upper Marlboro, MD 20772 Sally Jean Vitale/Wife Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) or other 1 XBurial 2 Cremation 3 Removal from State ment of 05/20/2009 Clinton, Maryland Resurrection Cemeterv Donation 5 Other Specify: 21. Signalur 1/F eral Service Licensee 22. Name and Address of Facility eorge P. Ka as unera ome 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. /Medical Death a. Contact Gunshot Wound of Head Immediate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown g Unknown signed by the betache 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 ✔ No 3 Probably 4 Unknown Records, P. Completed 24a. Was an 24b. Were autopsy findings available certificate has been page 2 should autopsy prior to completion of cause of performed' . death? 1 🗸 Yes ✓ Yes 2 After this certific funeral director, J To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Hospital: 1 Nursing Home 5 Residence 6 Other: Scene DOA Inpatient 2 ER/Outpatient 3 1 V Yes 28a. Date of Injury FOUND: 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Certification Subject shot self In 24 hours after usuallie Funeral Director: A' FOUND: Natural Yes 2 ✔ No Pending May 15, 2009 0710 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 13906 West End Farm Road, Upper Marlboro, MD (Specify) yard Homicide 29a. Certifier 1 completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical To the 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) May 16, 2009 O.C.M.E. reena 10. Nome and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Laron Locke MD. 31. Date filed (Month, Day Year) **WAY 18** 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death **Physician** 12:17 p.™ JOHN KENNETH WARRENFELTZ May 27 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Loyalton of Hagerstown Hagerstown Under 1 Year | If Under 24 Hrs. | 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth (Month, Day, Feb. 24, 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 ☑ M 2 □ F Maryland Feb. Ĩ⁄923 Director 86 219**-**12-0476 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or items 23a or 28a-f show any injury or other traumatic event, Ite Modical Exercises Trust by Attendance. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2♥ No Frederick Myersville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11232 Church Hill Road 21773 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: White 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Animal Technician Research 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be T. Warrenfeltz Susan Willard Ira Amy ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth E. Warrenfeltz/son 15 Locust Blvd., Middletown, MD 21769 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State □Other (Specify) St.Mark's Lutheran May 30, 2009 Wolfsville, Maryland 4 □ Donation vio Licensee 21. Signature of Fu 22. Name and Address of Facility 504 Main Street Ricketts Funeral Home Myersville, MD 21773 23a. Par/1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Corenny MYOCH DITHME NEEKS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 1) EMENTIA MUVANCED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has be rector, page 2 s 24a. Was an autopsy 1 ☐Yes 2 No 1 ☐ Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA MSSISTED LIVING this Certification: To 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation neral Director; β filled in by the for 1 ☐ Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

15

State Registrar 29b. Signature and title of certifier

GIMM

31. Date filed (Month, Day, Year) 32. Registrar's Signature

1190

MT

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

DADIN

ANTHA

RO AD

Trachs TO WW

09-03891 Alicia Williams Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Williams		State of Maryland	/ Department of Certificate of	r Health and f Death	Mentarriygi		20	09 1/95
		For State egistrar	Certificate of	Death		Reg. No ate of Death		3. Time of Death
Physicia		Decedent's Name (First, Middle,Last)			l M	ay 16, 2009	Year	0001 hrs
Bical Examir		Alicia Alvonse Willia Racility Name (if not institution, give street and number	1 m.s.	4b. City, Town, or L		4	c. County of Death	
		Northwest Hospital Center		Randallstowr			Baltimore Cou	1
Funeral			ige (In yrs. last birthday)	If Under 1 Year		Date of Birth (MN	(/DD/YYYY) 9. Bir Co	thplace (State or Foreign untry)
Director	- 1	267-65-8146 1 M 2XF	37 Yrs	Months Days	Hours Min.	Jan. 14	, 1972	""" Florida
	H	Usual Residence of Decedent						10d. Inside City Limits
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he M	Director	12 Wyndmoore Place		21207			S.A.	ican Indian, Black,
3, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho tranumatic event, the Medical Examingr must be notified at once.	eral	11. Marital Status 12. Was Decede Armed Force		as Decedent of Hisp	oanic Origin? (Specif Mexican, Puerto Ric	y Yes or No- an, etc.)	White, etc.	Tean Indian, Black,
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5-0036 iled within 7 Hygiene. I other than	Completed	17. Father's Name (First, Middle, Last)			18.Mother's Name (Fi	rst, Middle, Maid	en Surname)	
filed I Hyg					Cheryl	Owens		
2121 suld be fi Mental J marked ic event,	To Be	Jimmie Badger 19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ing Address (Stree	et and Number or Rur	al Route Number	City or Town, Sta	te, Zip Code)
MD 2 d 2 shou lith and D m 27 is r		Cheryl Badger/Mother	125	7 Carl 1	Drive,Fa	irfax,	South Ca	arolina ²⁹⁸²
Imore, MD 21 Pages 1 and 2 should nent of Health and Me lant: If item 27 is ma or other traumatic ev		20a. Method of Disposition	20b. Place of Dispo	osition (Name of ce	metery, L	pate 20	ic, Location - City C	0 1-
lore liges 1 it of 1: If i	1	1X Burial 2 Cremation 3 Removal from	Bryingto	n Bapti	st 5-2	4-09 7	Allenda	le, South Le, Carolina
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Ba perm Depa Imp	Ĺ	21. Signature of Fulletal Set vice Electrises Machael F. Machael Company Complications that cau 23a. Part I. Enter the disease, or complications that cau		009Harf	ord Road	<u>,Baltir</u>	nore, Mar	ryland21214
Physician		23a. Part I. Enter the disease, or complications that cau	sed the death. Do not enter	er the mode of dying	, such as cardiac or r	espiratory arrest,	snock, or near	Between Onset and Death
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.amine		or condition resulting in death) Due to (or as a c	onsequence of):					
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760 icate l		IF FEMALE: 23c. If yes, or 23b. Was decedent pregnant in the 1 Live bir	utcome of pregnancy	Fetal death 3	Ectopic pregnan	су	Month	Day Year
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/ita siciar is cer	director, page	examiner? Hospital:	npatient 2 🗸 ER/Outpati	tient 3 DOA	Other Nursing	,,,,,,,,		Other:
Sion of Vital Records, P.O. Box 68760 Attending Physician: The law requires that the death certificate releath. ector: After this certificate has been signed by the attending physician.	ᅙ F	27 Manner of Death 28a. Date	of Injury 28b. Time	of Injury 28c. Ir	njury at Work?	28d. Describe ho	w injury occurred	
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Division tal or Attendings after death.	filled in by the fune	2 Accident Investigation 28e. Place 3 Suicide 6 Could not be	e of Injury - At home, farm,	street, factory, offic	e building, etc.	or Town, Sta		Rujai Route Number, Orty
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Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director:	20	_ 29d. Celtillel 4 Continuing Physician: To the bes	t of my knowledge, death o	occurred at the time	, date and place, and ion, death occurred a	due to the cause at the time, date a	(s) and manner as nd place, and due	to the cause(s)
To the within To the	omple:	allu illalliler s	tated.		ense number		29d. Date signed	(Month, Day, Year)
- st	٥	29b. Signature and title of certifier			C.M.E.		May 16, 2009	
		Yank Pruthalle	40		O.171.E.			
~		30. Name and address of person who completed cau	se of death (Item 23a) Medical Examiner	111 Penn Str	eet, Baltimore, I	MD 21201		
		I Damala E Coritball MD Aggistant	IVIEUICAI EXAITIINEI					
5			egistrar's Signature					

3. Time of Death

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Year

State Registrar

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31. Date filed (Month, Day, Year)

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2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item 10f State of Maryland / Department of Health and Mental Hygiene Registrar WCHD/SH 5/28/09 per FH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month Dorothea Mae WELLER 0 9 /Medical 2 1 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 20416 Leitersburg Pike Hagerstown Washington 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Year) 214-34-9992 1 □ M 2 1 1 F Director 74 1935 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at Maryland Director Washington Hagerstown 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20416 Leitersburg Pike -21740 21742 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must any Injury or other traumatic event, the Medical Examiner must once. USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white Specify: þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) bookkeeper photo store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Sylvanus Weller Ida Mildred Hogan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Gelwicks - daughter 19711 Marigold Dr., Hagerstown, Maryland 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park | 5/27/09 Hagerstown, Maryland 21. Signature of Funeral Service L 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** HURRYLENSIUM disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner pidemia Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Examin physician and s the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical ending p IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 1 Live birth 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 Yes 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown been s Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has b 24a. Was an autopsy performed?

1 Yes 2 No Attending Physician: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury ours after death. 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide ö To the Funeral Completely filled i To the Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0060396 05/12/19 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MURSHED 1126 Opai Court Hagerstown mo 21740

State Registrar 31. Date filed (Mont

DHMH 17 Rev 1/2001

32. Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 2009 PM inator /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner WALDORF CENTER GENESIS HEALTHCARE CHARLES WALDORF If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MARCH 28, 1949 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. 1 □ M 2 V F MARYLAND 214-58-1179 60 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show notified at 1 X Yes 2 □ No WALDORF Director MARYLAND CHARLES 10e, Street and Number 10f. Zip Code 10q. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 50 TADCASTER CIRCLE 20602 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify Specify: <u></u> BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 72 (Give kind of work done during most of working life. DO NOT use retired) 10TH GRADE College (1-4or 5+) VOLUNTEER PRIVATE permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygic Important; If item 27 is marked other tany Injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be NELLIE MADELINE (GUTRICK) WASHINGTON WILLIAM JOSEPH WASHINGTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BROTHER 5327 HOLLY STREET, INDIAN HEAD, MARYLAND 20640 WILLIAM R. WASHINGTON / 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 □ Cremation 3 ☐Removal from State MT. HOPE CHURCH CEMETERY MAY 26, 2009 NANJEMOY, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21 ture of Furum Servicence THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 MADIA C. THORNTON JUINSON MO0583 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ardio Immediate Cause (Final norare **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Se uentially list conditions se uentiali, list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transit Due to (or as a consequence of) attending physician Physician/Medical the as IF FEMALE nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 □Ectopic pregnancy for in the past 12 months? 1 Yes 2 No 9 Unknown Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death the detached 9□Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform certificate 1□ Yes 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes Other: 2 No P 1 Inpatient 2 ER/Outpatient 3□ DOA Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 5 ☐ Pending investigation 2 _\Accident death. M 1 ☐ Yes 2 ☐ No in by the within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Box 68760. P.O. Division or Vital Records, Physician; or Attending

Maryland 21215-0036

Baltimore,

To the Hospitai

State Registrar

ical

Medi

29a. Certifier

30. Name and

(Check only one)

29b. Signature and title of certifie

E 101 31. Date filed (Month Registrar's Signature

ted cause of death (Item 23a) (Type, Print)

Office Rd, Walder 051

1 XcertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) 009

0061652

Amend 17 & Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ARY **Physician** Year 1113 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis <u>Anne</u> Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Min. 12 M 2 □ F Months Davs Hours Director 218-90-1951 2/3/1965 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, Itin Madical Examinate must be notified at Director 1 XYes 2 No Maryland Anne Arundel Annapolis 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1112 Hoover Street USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: **Black** 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If them 27 Is marked other the any Injury or other transment. St Mary's Church Cook 18. Mother's Name (First, Middle, Maiden Surname)

Mary Louise Thomas

Mary Thompson-17. Father's Name (First, Middle, Last) Be Howard Carroll Williams
Carol Howard Williams ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1104 Niblick Ct, Arnold, MD 21012 Robin Coulter - Companion Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Baltimore Crematory 5/18/2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home, Inc 21. Signature of Funeral Service Licenses T. 147 Duke of Gloucester St, Annapolis MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) attending physician for use as the hurial Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) JYes 2 □ No P.O. signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 certificate 2 No 1 ☐Yes 2 ☐ No 1 □Yes Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this, completely filled in by the funeral dir Medical Certification: To this Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29b. Signature and title of/certifier 29d. Date signed (Month, Day, Year) un Name and address of person who completed cause of death (Item 23a) (Type, Print) 445 DEFENEHIGHWAY State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1105 MARCIA 5 Ô /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Edgewater Anne Arundel 1420 Hallie St. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday 6. Sex **Funeral** Months Hours 1 M 2 F Days Min 12/18/1930 579-42-1826 78 Washington, DC Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No Director Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21037 1420 Hallie St. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🗓 No If Yes, Give Year or Dates: Specify: White Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker At Home of Health and Mental Hygis item 27 is marked other r other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anton Felix Sniegoski Madelle Grant 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) James Walker/Son 1510 W. Mt. Harmony Road Owings, MD. 20736 permit. Pages 1 a
Department of Hei
Important: If item
any injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 M Burial 2 □ Cremation 3 □ Removal from State Maryland Veterans Cemetery5/20/09 Crownsville, MD. 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home Funeral Service Censes 21. Signatur 2973 Solomons Island Rd. Edgewater, MD. 21037 Part 1. Enter the disease, or complic tips that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on sause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 8 /Medical Due to (or as a consequence of): enternio Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying tusk (Liss of jury) that initiated events resulting in death) Last Examiner Due to (or as a consequence of): sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. attending physician Physician/Medical as the l use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy ρĮ Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a d be detached fo P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 No 1 🗌 Yes 3 Probably 4 Unknown icate has been si , page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy certificate 1 ☐Yes 2 No Hospital or Attending Physician: director, 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2☐No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation hin 24 hours after death. the Funeral Director: Aft mpletely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2

State

Registrar

31. Date filed (Month, Day, Year) 18

Name and address of person who complete

29b. Signature and title of cert

un Régistrar's Signature

use of death (Item 23a) (Type, Print

45 DEFENSE HIGHWAY ANNAPULISMANGE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend State of Maryland / Department of Health and Mental Hygiene Items 21,22 per fn, 892,06/04/09dhb Reg. No. Reg. No. 2 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May Month 20⁶9 4:45 A M **Physician** Shirley Ann Youngblood /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Frederick Frederick College View Center If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Feb 2ay, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months 1938 Virginia 1 □ M 2**E** F 71 Director 223-50-3858 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show filed within 72 hours after death with the Maryla Hygiene.

Other than "natural", or items 23a or 28a-f showent, the Marylal Examinal must be notified at 1 ☐ Yes 2 No Director Winchester VA Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 22603 161 Glengary Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Caucasian Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ ¥⊠ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Own Home Homemaker is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event Elsie Rebecca Hovermale Eldon LeRoy Bohrer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 161 Glengary Road, Winchester VA 22603 Donna Youngblood - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 5/6/2009 Frederick Co., VA Howard's Chapel Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Omps Funeral Home, 1600 21. Signature of Funeral Service Licensee Amherst Street, Winchester, VA 22601 A. Lola March per dvr 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dementia /Medical Due to (or as a consequence of): **Examiner** Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (area a normicularies off Examine Hospital or Attending Physician; The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical certificate has been signed by the attending prector, page 2 should be detached for use as i IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 2X No 9 Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 9 Cachexia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4XXNursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 ☐ Pending 1 □Yes 2 □No investigation 24 hours after death 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 D60417 30. Name and address of person yno completed cause of death (Item 23a) (Type, Print) Thomas Johnson Drive, Frederick MD 21702 Hemen Shah, 65C . Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month ^{Day} 2009 **Physician** Anderson, Sr. June 6:25 P. William Carl 2, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death Union Hospital Cecil Elkton 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Dec • 8 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral X** M 2□ F Months Days Hours f926 Mary land 216-20-2460 Director 82 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No event, the Medical Examiner must be notified Directo Maryland Harford Darlington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4135 Flintville Road or items 23a 21034 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 25 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 21215-0036 Specify: White 1 ☐ Yes 2 XXNo ģ 3 ☐ Widowed 4 ☐ Divorced Specify. Year or Dates "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within Elementary/Secondary (0-12) than College (1-4or 5+) Welder Manufacturing marked other Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be fi George L. Anderson, Sr. should Injury or other traumatic 2 May Duff 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any Injury or other traum Dorothy Mae Sheetz / Daughter 75 E. Lewis Shore Rd. Elkton, Maryland 21921 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Evans Funeral Chapel 1 ☐ Burial 2 Coremation 3 ☐ Removal from State June 4, 5 ☐ Other (Specify) 4 ☐ Donation Bel Air 2009 Forest Hill, Maryland e of Funeral Service 21. Signatu 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Service-Bel Air 3 Newport Drive Forest Hill, Maryland 21050 23a. Part1. Enter the disease, or complet tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 0 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 ☐ Pregnant at time of death 5 Other (specify) the þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Q. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2) 10 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA မ this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ä ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

1 24 hours a within 24

> State Registrar

29b. Signature and title of certified

31. Date filed (Month

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month/ Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 2009 10:40 PM June Ann Rose Anderson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Bel Air 8. Date of Birth (Month, Day, Year)
Aug. 27, 1931 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 XF Maryland 214-30-5273 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 X No Bel Air Maryland Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21015 2009 B Waverly Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2No Specify. Specify: White 9 22 40 Pm Maryland 21215-003 þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f Mary Rose Bishop Dennis R. Hill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2...
Department of Health a Important: If Item 27 is any Injury or other trau Richard Anderson / Son 2009 A Waverly Drive, Bel Air, MD 21015 Baltimore. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Grove Bapt. Cem. : 6-5-09 Bel Air, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Rd., Abingdon, MD 21009 21. Signature of Juneral Service Licensee (cusa Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** hespive ton /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and burial-tran Due to (or as a consequence of): the attending physician Physician/Medical as IF FEMALE nse yes, outcome of pregnancy
□ Live birth 2 □ Fetal death
□ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Por Month Day 5 Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed? Yes 2 2 No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 NO 1 ☐ Yes 1 Dopatient 2 ER/Outpatient 3 DOA P this completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Alatural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide Hospital or ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

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31. Date filed (Month, Day, Year)

<u>JUN 0 5 2009</u>

Registrar's Signatu

32.

M.D. 500 Upper Chesapeak

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